A Socio-Cultural, Political and Administrative Analysis of Health Policies and Programmes in India in the Eighties : A Critical Appraisal

Debabar Banerji

The book had to be written within a severe time frame because of its topical relevance. The medical profession and the health services are in the throes of a profound crisis. The morale of medical personnel in the health services has touched an all time low. There is a sharp decline in their competence and in the ethical standards. Corruption and political interference have become more rampant and blatant. Quality of education and training in medicine and public health has sharply deteriorated. Generalist administrators, who lack completence in public health practice and who can not be held accountable for their decisions, have been allowed by the political leadership virtually to hijack the health services of the country. These had far reaching consequences. The family planning programme has once again reached a dead end. The once highly respectable institutions like the WHO and UNICEF have given in to the pressure from affluent Western countries and they have succeeded in pressurising the country to retreat from the commitments it made in its own National Health Policy and at Alma Ata. Imposition of the Universal Immunization Programme on India by the outside agencies provides an awe-inspiring example. However, this selective approach has now once again been proved to be an expensive failure.

Interestingly, to rectify the situation in the field of health, India has only to regain its past heritage of public health practice which it had so assiduously cultivated over seven decades. It is endogenous in its origin. It situates health and health services in their social, cultural, political and economic contexts. The focus is on community self-reliance. It has been termed here as New Public Health. People, and not technology, forms the starting point of New Public Health.

An Analysis of Health Policies and Programmes in India in the Eighties

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LOK PAKSH

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PUBLISHER'S POSTSCRIPT

This book had to be produced in great hurry to be in time for presentation to the Planning Commission for consideration during formulation of the Health (Service) Sector of the Eighth Five Year Plan. As it was expected to the funded from the ICSSR-ICMR grant from its Health for All Projects, about a hundred copies were distributed to interested scholars, free of cost. However, as the ICSSR insisted (on November 11) that decision concerning publication of the book from the ICSSR-ICMR Project grant "would only be taken after it is discussed in the Advisory Committee likely to meet in due course", in sheer desperation, the author guaranteed the cost of the production and requested Lok Paksh to publish the book as a priced publication. Another legacy of the unfortunate association with ICSSR is the obviously cumbersome title given to the book to bring home to the health social scientists of the country (after experience of Chandigarh Conference, December, 1989) that important socio-cultural and political issues emerged as a result of a different methodological approach for this study

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Dedicated to the People of the Nineteen Villages of a Study (1972-88), who Taught me so much of Public Health.

Preface

The book had to be written within a severe time frame because of its topical relevance. The medical profession and the health services are in the throes of a profound crisis. The morale of medical personnel in the health services has touched an all time low. There is a sharp decline in their competence and in the ethical standards. Corruption and political interference have become more rampant and blatant. Quality of education and training in medicine and public health has sharply deteriorated. Generalist administrators, who lack completence in public health practice and who can not be held accountable for their decisions, have been allowed by the political leadership virtually to hijack the health services of the country. These had far reaching consequences. The family planning programme has once again reached a dead end. The once highly respectable institutions like the WHO and UNICEF have given in to the pressure from affluent Western countries and they have succeeded in pressurising the country to retreat from the commitments it made in its own National Health Policy and at Alma Ata. Imposition of the Universal Immunization Programme on India by the outside agencies provides an awe-inspiring example. However, this selective approach has now once again been proved to be an expensive failure.

Dealing with the wider malady, of which the sickness of the health system is a part, the new Planning Commission has come forward with some refreshingly bold ideas in its Approach Paper on the Eighth Five Year Plan: decentralisation, debureaucralisation, democratisation, people orientation of technology and intersectoral action. Interestingly, to work on these lines in the field of health, India has only to regain its

past heritage of public health practice which it had so assiduously cultivated over seven decades. It is endogenous in its origin. It situates health and health services in their social, cultural, political and economic contexts. The focus is on community self-reliance. It has been termed here as New Public Health. People, and not technology, forms the starting point of India's public health heritage. This approach has been reiterated and elaborated in this book. Struggle for health and health services is not merely techno-managerial action: first and foremost, it is a part of a wider social and political struggle.

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CHAPTER ONE

INTRODUCTION

The Indian Council of Social Science Research (ICSSR) and the Indian Council of Medical Research (ICMR) had formed a Joint Panel on Health. In the course of its deliberations, the Joint Panel had formed four sub-groups to launch four 'Health For All Projects'. These projects were: 1. A Critical Appraisal of Health Policies and Programmes in India in the Eighties; 2. International Environment, Multinational Corporations and Drug Policy; 3. Community Participation in Health; and 4. Privatisation of Health Care and Health Professionals. The Panel had formed an Advisory Committee for these projects. Due to various reasons, it was not possible to form the Sub-group-4. It was, therefore, dicided that Sub-group-3 will also cover these areas and the other two Sub-groups will also be free to include areas falling within Sub-group-4, if they find them relevant to their assignments.

The time allotted for the projects was exceedingly limited. While the funding was made in the middle of February, 1989, interim reports of the three Sub-groups were to be submitted to the Advisory Committee by the end of March 1989 for onward transmission to the Planning Commission, well in time for formulation of the health sector of the Eighth Five Year Plan. The revised time frame given for the final report was November 1989 and the reports were presented to a National Conference on Health and Social Sciences, held on December 8-9, 1989 at Chandigarh. Because of the severe time constraint, this book had to be produced in some hurry.

Under such circumstances, some typographical and editorial errors were almost inevitable. These errors are regretted.

In choosing only the four areas, the Advisory Committee was clear that the intention was to focus on specially selected areas; *it was not meant to be a comprehensive study of all the activities to attain Health For All.* For instance, it was not intended to cover intersectoral action on health or individual national programmes, or go into the details of the managerial processes, or take up such specific areas as women's health or workers' health or the Indigenous Systems of Medicine. Also, considering the severe time constraint, it was also understood clearly that it is almost impossible to do justice to the task assigned to each Sub-group and the effort would be optimise the time allotted to cover only the most important areas. This was particularly relevant to the task assigend to the author: to be the Principal Investigator of the Project under Sub-group-1.

The author dared to undertake such a daunting task because he had a life long interest in study of health systems, involving complex interaction of a very large number of variables. The intellectual challenge of making a systems analysis of health policies and health programmes, employing an interdisciplinary approach, turned out to be too tempting. First and foremost, the challenge was conceptual: how to conceptualise health policies and programmes in India as complex wholes, with all their numerous interdisciplinary dimensions? Then there was the formidable task of getting together data on different components of each dimension, their analysis and interpretation and their blending together to make analyses of individual sub-sub-system, sub-system and finally the entire system covering policies and programmes.

Issues related to political science dominate policy analysis. However, this also requires inputs from management, technology and its choice and other social sciences,

particularly sociology, cultural anthropology and social psychology. Obviously, analysis of health programmes has to be made against the policy, with all its interdisciplinary dimensions. However, in the case of programme analysis not only are the interdisplinary dimensions not always the same, but, more importantly, the emphasis is quite different, even when the discipline is the same: political considerations in policy analysis are quite different from those in programme analysis. Furthermore, the dominant input in programme analysis are from managerial and technological fields, along with their epidemiological and sociological perspectives. A distinguishing feature of the methodology adopted in this study is that here the central place is given to socio-cultural issues: socio-cultural issues concerning community perception and meaning of health problems and health practices have served as the moving force in examining the epidemiological, managerial and technological aspects of programmes. In turn, all these interdisciplinary issues are blended together to give a holistic, systemic view of the programme. In the final analysis, therefore, not only are there substantial inputs from the social sciences, epidemiology, management and choice of technology in programme analysis, but they are so intimately blended together that the final outcome becomes a composite mixture of a large number of ideas from a large number of disciplines where it becomes difficult to identify where one disciplinary input ends and where others begin.

The other challenge related to the sheer size and complexity of the health service system of the country and the constitutional provisions on union and state responsibilities in the field of health. There are complexities in the overall organization and management of health services at the union and state levels, with all their political, social, economic ecological and epidemiological diversities. Regional variation form a critical variable. There are distinct problems of organization and management at the village, sub-centre, New Primary Health Centre, Community Health Centre,

taluk/tehsil, district, division and state levels. Then, there are complexities of planning, formulation, implementation and evaluation of the numerous special programmes — e.g. various national health programmes, family planning programme and maternal and child health programmes. Over and above, there are the critical 'staff' inputs at various levels in the form of health manpower development, health systems research, management information system, transport and supply of drugs and equipment. An interdisciplinary approach of systems analysis is required to be applied to study such a complex system with its extensive ramifications throughout the length and breadth of the country.

The other major challenge was to get together the information needed for making an appraisal of such a complex system. This was a particularly difficult problem when the dominant culture is to use bureaucratic rule of thumb in decision making. Data base for decisions made was often very weak and tenuous. There was, in addition, the tendency to withhold even the very limited data, presumably as a measure to protect the existing decision making process. From the standpoint of this study, it became particularly important to get hold of as much of the information as possible. It meant a great deal of effort. Because there is so little of the information existing and the difficulties in having access to them, they are being presented separately as Annexures in this monograph. Annexure 'A' contains references to health policies and the numerous programmes and the organizational structures, mainly at the state level. Some other relevant references are presented as Annexure 'B'. These are being cited as supportive references for many of the contentions made in various chapters, in addition to the references specifically cited. These can also be of use to other scholars who might study this area.

Originally, ICSSR had intented to bring out an edited monograph, incorperating the reports of the three Sub-groups, soon after the National Conference on Health and

Social Sciences. However, due to various reasons, that could not be done. Moreover, the author could get only limited feedback on his report from the participants of the National Conference and from an anonymous reviewer selected by ICSSR. Considering that this study is based on an endogenously developed interdisciplinary methodology, using a systems approach, where the starting point of appraisal of health problems are the beneficiary, that is the people themselves, it was felt that no further time be lost and expose the ideas developed to larger body of scholars of health services. An additional justification for bringing out the report as a monograph is that it can be used as an input for the formulation of the health sector of the Eighth Plan by the new Planning Commission which came into being in December 1989. It is not known how far the documents prepared by the Working Groups on the health sector of the previous Planning Commission was actually used for plan formulation. One can only hope for a better luck this time.

The conceptual background of the methodology adopted (Chapter One) is the most distinguishing feature of this presentation. It is represents an endogenous effort, based on experience of more than seven decades of public health practice and research. It tends to find an Indian way of studying India's health policies and programmes.

An interesting outcome of this methodology is the combination of a 'study from below' with the conventional 'study from the top'. Primacy is given to 'a study from below'. It is for this reason more than a fourth of the space is given to data on community perception and meaning of and community response to health problems, community felt needs and the organization and management of health services in rural areas, communities' eye view of the various medical and health institutions, commodification of medical services and community response to the programmes of mass communication and education in health and family welfare (Chapter Five). This is the centrepiece of the report.

This sharply brings into focus the most critical defect in the health programmes, namely the quality of decision making (Chapter Six). Along with a sharp decline in the quality of public health practice, associated with a most defective cadre structure for technical personnel, there is the most dangerous trend of involvement of generalist administrators in technical decision making for which they simply lack competence. The devastating consequences of adopting such an approach are discussed in the following five chapters.

One of the purposes of the project has been to relate the present situation to the ideas contained in the Report of the ICSSR-ICMR Study Group on Health For All (Chapters Two and Thirteen) and to the National Health Policy (Chapter Three). While making a very critical analysis of the health policies and programmes, care has also been taken to point out at the very beginning (Chapter Four) that despite the many problems and setbacks, there have been most significant gains. In the critical areas of policy commitment, demonstration of political will, manpower development, formation of key research institutions and building up of the network of infrastructure of health services, India occupies a distingished position among nations of the world facing similar epidemiological, economic and socio-cultural conditions.

Political commitment to health service development over the past seven decades has led, almost unwittingly, to the generation of a body of knowledge — methods, concepts and practices — which is qualitatively different from the conventional knowledge in Western countries, including that which existed when the economic and epidemiological conditions in those countries were similar to that exists in India to-day. On that basis, the endogenous body of knowledge developed in India can be given the name of New Public Health. Indeed, the central position given to some key social science issues in this appraisal is also the outcome of India's long tradition of using social sciences in health fields.

Data presented here, including their blending with managerial, technological and epidemiological data, also represent at least a new trend in the development of endogenous efforts in the use of social sciences in health service development in the country — New Social Sciences in Health?

The author has freely used his own previous writings in preparing this monograph. He has attempted to link his writings with the works of other scholars to develop an interdisciplinary overview of health policies and programmes in India. That, indeed, was the agenda for this project. Imperical evidence was then integrated with this overview to give it a substantive form. Holism is the running theme here. A critique of this works ought to focus on this holistic approach. Critique of individual concepts that have been used ought to be confined only in so far as these concepts have been used for developing a holistic perspective. Critique of the imperical evidence presented here should form the third tier of criticism. A well-informed and a balanced criticism of this work will be most valuable contribution to the growing body of knowledge concerning concepts, practices and research in the discipline of public health in India. This monograph has been prepared to actively seek out such criticism.

CHAPTER TWO

A CONCEPTUAL BACKGROUND TO THE METHODOLOGY OF THE APPRAISAL

A critical appraisal of health policies and programmes in a complex and big country like India is a formidable task, conceptually as well as methodologically. As will be discussed later on, health service development of a country is an epidemiological, socio-cultural and a political process, rooted in its history and its changing ecological and demographic setting. It is also a managerial and a technological process, with their own epidemiological and sociological dimensions.

The venerable Bhore Committee (Government of India 1946) had made perhaps the most extensive study of health services of the country. Although it adopted the age-old bureaucratic 'committee approach', it had in it a large number of highly competent and motivated members, who took full advantage of the ample time and resources made available to it. The other two major committees, which also adopted a committee approach—the Sokhey Committee (National Planning Committee 1948) and the Mudaliar Committee (Government of India 1962)— fell far short of the Bhore Committee in terms of methodological rigour. The more recent ICSSR-ICMR (1981) Study Group on Health For All: An Alternative Strategy, which forms the starting point of this report, has distingished itself by at least attempting to

situate health services in their social, economic and political contexts and adopting an inter-sectoral approach. However, it also adopted the 'committee method' and, as will be pointed out later, it is much weaker in terms of epidemiological and administrative and social science analysis and perspective. Even though the mandate for the current study is very much more modest and the time constraint is very severe, an attempt will be made to adopt a more comprehensive conceptual and methodological approach in making the appraisal and offer a perspective for the future.

Appraisal of health policies in India requires consideration of a wide range of issues, falling within a number of disciplines. Here, epidemiological, medical and public health and organizational and management issues are visualised in their social, cultural and economic settings to crystallise them in form of policies, which are based on constitutional and other types of political commitments. In the Indian Constitution, health is primarily a state subject. However, using some very powerful devices available to it, such as controlling international assistance, launching of centrally sponsered and centrally aided helath programme, using a centralised approach to planning and influencing the bureaucrats belonging to Indian Administrative Service (IAS), the Union Government has acquired a virtual monopoly position in shaping the health policies: notwithstanding their constitutional prerogatives, states have been reduced to the position of supplicants before the Union Ministry of Health and Family Welfare and the Planning Commission and they are compelled to implement the policies laid down by the Union Government.

Appraisal of health programmes is even a more extensive and complicated process, because it has to deal with a very big and highly complex system. There are complex epidemiological dimensions of the health problems. These dimensions are to be situated in their social and cultural contexts. The health programmes, in terms of their

organizational structure, managerial processes and choice of technology are to be related to the epidemiological and socio-cultural conditions. Over and above, there are other important components of the system, such as manpower development, research inputs, the national health programmes, population control, hospitals and medical care, centre-state relations, international assistance and financing of the health services.

Thus, a study of health programmes in the eighties involves study of highly complex systems. Each of the system has a number of sub-systems and sub-subsystems, and so forth and each of them having a number of components in complex interaction with one another. The Family Welfare Programme, for instance, ought to be visualised within such a complex, interacting systems framework: variation in one component (say, use of a new contraceptive) will have wide ranging repercussions, which transcend the boundaries of any specific sub-system (Mishra et al 1982).

One of the foremost tasks for appraisal of health programmes will be to define the boundaries of systems and sub-systems which constitute the different elements of the overall health service system and identify the key variables which in the main determine the working of the complex. Such a framework thus not only helps in identification of the key variables, but it also allows assessment of these variables in their systemic contexts. It follows that the methodology for appraisal of a health programme will require a study and analysis of the key variables against the background of a systemic conceptualisation of the programme. This also sets the stage for adopting different research tools to find out how best to reorganize the system to get the maximum returns from investment of resources (i.e., optimisation of the system through systems analysis) and to identify key areas where investment of additional resources will lead to high output (through the use of technique of operational research).

It may also be noted that systems of health services are, because of their very nature, intrinsically dynamic in character, because the variables undergo changes in the very process of operation of the system. Therefore, it is necessary to take into account the intrinsic dynamics of systems within a time dimension, even when attempts are made to optimise systems through internal manipulation or to form new systems which are meant to provide conduits for investment of additional resources to cover hitherto uncovered areas (e.g. immunization programmes for communicable diseases). The importance of this approach is now being increasingly realised (Mishra et al 1982; Banerji 1972).

Obviously, making a detailed study of the health services system in India on the above lines will require great deal of time and resources. With the increasing realisation of the critical importance of use of health systems research, both nationally (Banerji 1972) and internationally (WHO 1983b), for quite some time it had become an important tool for research. However, for the present study it is simply not possible to have the time and resources to make a compreehensive analysis of the system.

Nevertheless, it is possible to adopt an *approach* of systems analysis and operational research (see, for example, Banerji 1972) even within the very severe constraints of time and resources. This is a very important feature of methodological framework adopted here. More than anything else, this requires an *attitude*, where the concern is to understand programmes or services as a whole, as an organized complexity, within which a number of components are in a state of dynamic interaction with one another. This methodological approach ensures that positive efforts are made to bring together the pre-existing knowledge and data concerning the system with a view to making a more systematic evaluation and to propose new lines of action. It can be seen that this is *qualitatively* different from the time honoured bureaucratic approach of forming committees of a collection

of individuals, often of diverse levels of perception and commitment, to the task assigned. There is often a secretariat to feed the committee with information, sometimes collected by commissioning special papers, and the committee arrives at conclusions of far reaching character after holding a few periodic meetings. As will be pointed out later, this patchy and superficial approach to study has led to simplistic aproaches to complex problems, often ending up in considerable waste of valuable resources and time.

DATA BASE

It needed major efforts to get together some of the crucial information to develop a systems approach to appraisal of health programmes. That was a very difficult task. Often information was simply not available concerning critical components of a number of systems: under such circumstances, development of 'best guesses', based on circumstantial evidence, was the only way out. An even more difficult task was to get hold of the available information. This needed a great deal of effort.

The Documentation Unit of the Centre of Social Medicine and Community Health of Jawaharlal Nehru University happens to be an important repository of some of the key information needed. A special drive was launched to update and reinforce the already available information by locating and obtaining needed documents.

The important documents used in the present study are listed under Annexure 'A'. Additional references are given in Annexure 'B'. The main categories of information are:

1. Publications from the Union Ministry of Health and Family Welfare and its Directorate General of Health Services form the sheet anchor of the data bases for this study. They include the latest available editions of the annual report of the Ministry of Health and

Family Welfare, Yearbook of Family Planning, Agenda Papers of the meetings of the Central Councils of Health and Family Welfare, *Health Information of India, Rural Health Services in India,* and so forth.

2. A special effort was also made to obtain information concerning the status of health services in the different States of the Union. It has been possible to obtain the latest reports from a number of key states. Of particular significance was the draft for the health sector for the Eighth Plan from the State of Uttar Pradesh and a detailed report on the various health institutions available in the State of Rajasthan. Important documents were also obtained on the situation in the states of Kerala, Karnataka, Andhra Pradesh, Madhya Pradesh, Bihar, Goa, West Bengal, Punjab, Himachal Pradesh, Jammu and Kashmir, Nagaland, Meghalaya, etc.

3. A number of documents produced by other institutions also provided some key information for the study. The report on the very extensive cooperative study on maternal and child health organised by the Family Planning Foundation of India, the report of the Lentin Commission on JJ Hospital, the ICMR study of 198 PHCs, primary health centre studies carried out by the Operations Research Group, the district level child mortality estimates published by the Ragistrar General, the report of the Programme Evaluation Organization of the Planning Commission on family welfare and the baseline studies carried out in connection with the Area Projects are included in this category.

4. Another important source of data for this report is the long term (1972-88) in-depth micro-study of nineteen villages in India, including study of eleven

primary health centres. Besides, a number of research scholars of the Centre of Social Medicine and Community Health have also obtained valuable data on various aspects of health services in the country.

5. The Project Investigator had brought together a number of his ideas in two of his books entitled, *Health and Family Planning Services in India : An Epidemiological, Socio-Cultural and Political Analysis and Perspective* (Lok Paksh, 1985) and *Social Sciences and Health Service Development in India: Sociology of Formation of an Alternative Paradigm* (Lok Paksh 1986). Naturally, these ideas have been freely used in the preparation of this report.

6. The Project Investigator also had discussions with some key functionaries at the union and state ministries of health and family welfare on certain specific areas that are of relevance to the project.

CRITICAL ROLE OF SOCIAL SCIENCE INPUTS

This account of health policies and programme in India has brought forth some very interesting new areas in the use of social sciences in health fields. India is among the first countries of the world where role of social science inputs in health service development was recognized and social scientists were employed in health organizations in such fields as medical education and education and tranning of other health workers, health education, health planning and in the formulation of health programmes and their evaluation (Banerji 1986b). Expectedly, as in so many other fields of sociology of knowledge, the early phases were marked by pronounced dominance of the field by concepts and methods developed mostly in the United States. Endogenous efforts were not encouraged, if not actively ignored. One unfortunate consequence of this was that the people became the subject

of manipulation by social scientists, health educators and mass communicators, so that they (people) conformed to programmes that are handed down to them from 'above' (See, for example Manoff 1984; Mahler 1982; WHO 1983a). Infiltration of the market forces to 'sell' medicine/health as commodities (e.g. vitamins, tonics, unnecessary operations, mystification of medicine, and so forth) was a logical consequence of this approach (Illich 1977) .

However, India's quest to relate its medical and public health services to the people has led to the formation of an alternative social science approach, which starts from the people, rather than from medical technology (Banerji 1986: 95-105). It attempts to relate technology to the people, rather than the other way round, as has been the case earlier. Instead of using social sciences to manipulate people to fit them in a technological mould, this approach attempts to manipulate technology to fit it with the felt needs that are generated in people by health problems: those felt needs that also overlap with epidemiologically assessed needs (WHO 1983a). Here, there is no blaming of the victim. If anything, there is blaming of technology, when it is inappropriate, distorted, irrelevant or exhorbitantly priced. This approach also underlines the fact that health behaviour is not an isolated, cultural trait; it interacts closely with the cultural meaning and cultural perception of health problems, on one hand, and the people's access to health institutions which can alleviate their suffering, on the other. This complex 'system' has been termed as *Health Culture* (Banerji 1986b:99).

Formation of this dichotomy of social science approaches to health field led to consideration of issues concerning sociology of knowledge, and subsequently, to the very important issues of political economy of health and health services (McKinley 1984; Banerji 1984b). This was developed further to take into account historical and ecological bases of health service development in the country (Banerji 1985a: Jeffery 1988). Issues such as felt needs and health culture

come under sociology IN medicine and sociology of knowledge and political economy of health and health services under sociology OF medicine (Straus : 1957). All these categories of concepts are briefly elaborated below, because they are of considerable relevance to the present study.

Because of their highly developed nervous system, human beings have been constantly interacting with their surroundings to develop different patterns of their ways of life, that is, their cultures. In this process of interaction and cultural development, they have acquired considerable control over nature and also over their fellow beings. Development of means of production and production relations is a part of this complex process. Health problems of a community can also be seen as outcome of interactions between (i) causative agents and (ii) human hosts, (iii) mediated by the environmental (or ecological) conditions. Thus, incidence and prevalance of diseases in a community and the cultural response to the diseases and consequent changes in the population size, all arise out of interaction between the ecological conditions, causative agents and human hosts. In other words, study of health and health service development in a community includes study of environmental factors and causative agents (ecology and biology), incidence and prevalence of health problems (epidemiology), cultural response to the health problems (cultural anthropology), changes in the means of production and production relations (political economy) and dynamics of the population size (demography).

By their very nature, the interdisciplinary parameters that are involved in this complex interaction undergo changes with the passage of time. In other words, the interaction also has a historical dimension. The changes in the means of production and production relations in the course of time have also brought about major changes in the culture and therefore in the social structure. Changes in the patterns of health problems and changes in the means of coping with

these problems also form a part of the basic changes in the socio-cultural process. In turn, changes in socio-cultural processes trigger changes in political processes which, in turn, mediate a community's response to its health problems. Therefore, against an ecological, cultural and historical background, the health status and health services within a community in a given time is an outcome of a given socio-cultural and political process. This approach is being adopted here to understand health and health services as they exist in India today.

Formation of knowledge for dealing with various health problems and actual access to the helath practices based on such knowledge are two different issues in understanding health practices within a community. The nature of the social structure determines the gap between the available knowledge and its access. Indeed, social structure also determines the generation of knowledge. India can hark back to its rich heritage of medical science and technology by pointing to the sanitary practices of the people of the Indus Valley Civilization and the works of various scientists during the Buddhist and subsequent periods which formed the basis of the writings of Charaka and Susurata (Chattopadhyaya 1977; Zimmer 1948). Subsequently, with the development of contacts with the Islamic culture, the knowledge of Unani system of medicine became available. The Siddha system of medicine developed in the Tamil Nadu region.

Throughout this long historical (essentially feudal) period, which ended with the British conquest of India, it is possible to surmise that the access to the technology developed was mainly limited to the ruling classes. For the large masses of the people health practices consisted of some local adaptation of Ayurvedic, Unani and Siddha systems of medicine, along with formation of various forms of folk medical practices, home remedies and various types of supernatural and religious practices.

Thus, basic characteristics of health practices of this period was that there were two types of medical practices: one for the previleged classes and other for the broad masses. Raj Viadyas and Shahi Hakims were meant for the privileged classes. The masses were left to improvise their own ways of coping with their health problems, depending on their capacity to gain access to various forms of knowledge.

The advent of the colonial rulers brought about further complexities in the profile of the social structure and also of the health practices. The colonial rulers became by far the most dominant stratum of the society, with the native society remaining polarised between the privileged classes and the masses. A still further complication arose when the British brought in the science and technology of the Western system of medicine. This meant, at least to some sections of the native population, interaction between the pre-existing pattern of perception and meaning of health problems, helath institutions and health behaviour of the population (i.e. the pre-existing health culture), on the one hand, and the values of science and culture embodied in the Western system of medicine, on the other. The complexity increased still further with the passage of time, when there had been rapid growth and development in the knowledge and practice of Western medicine due to major discoveries and inventions. Besides, there were also the inevitable consequences of colonial exploitation and plunder which created ecological conditions which were conducive to higher prevalence and incidence of various kinds of diseases; it is also likely that it also contributed to increase in frequency and severity of famines and epidemics.

Still another important complicating factor was the effort by an increasing number of people to gain access to Western medical services, as many of these services were increasingly perceived by them as more effective ways of coping with their health problems. This increasing demand for more effective health services for people had also become one on the planks for the National Movement. Wider popular participation

following enactment of the Government of India Acts of 1919 and 1935 led to some expansion of the health services (Jeffery 1988: 73-74). Report of the National Health (Sokhey) Sub-committee of the National Planning Committee (1948) and the Health Survey and Development (Bhore) Committee (GOI 1946) provided the basis for preparing a blueprint for development of health services in independent India.

However, when independence did come, while the political leadership continued to renew their commitment to the lofty egalitarian pronouncements made during the anti-colonial struggle, they used essentially the same machinery which was bequeathed to them by the colonial rulers to ensure that the fruits of independence benefited them most and that they are able to perpetuate their hold on the government of the country.

Thus, a noteworthy feature of health service development in India is that, throughout the past century and a half, it has been influenced by two powerful forces pulling it in different directions: the colonial values and practices, which continued to be nurtured by the privileged class after independence, pulling in the direction, and the anti-colonial struggle, which, after independence, took the form of struggle for democratisation, pulling in another direction. This sums up the trends in the political economy of health and health services in India.

In following the policy frame for health services which had begun to take shape during the National Movement, independent India embarked, step by step, on implementation of a comprehensive rural health service through Primary Health Centres, health planning as part of the national socio-economic plan, mass campaigns against communicable diseases, social orientation of education and training of various kinds of health workers, population control through a national programme for integrated family planning, promotion of indigenous systems of medicine, provision of

adequate water supply and environmental sanitation and nutrition programmes, culminating in the launching, in 1977, of the Rural Health Scheme for entrusting the, people's health to people's hands', through health workers chosen by the community (Banerji 1985a:23-28).

While the masses wrested these rights from the ruling class, the latter's class interests ensured that, through rearguard actions, none of these obviously laudable programmes is implemented properly.

An interesting feature of this presentation is that here the starting point of appraisal of the health services is the beneficiary, namely the people concerned. Enough social science data on health behaviour of the people in rural areas are now available to attempt to find out to what extent those felt needs of these people, which also happen to be the epidemiologically assessed needs, are being met by the health services. This sociological approach provides a very interesting perspective to study the functioning of some of the key health personnel who are meant to provide direct services to them, namely the village guides, male and female multipurpose workers and health assistants, physicians and other personnel at the New PHCs and the Community Health Centres and the entire referral chain, extending from taluk or sub-divisional hospitals, district hospitals, urban general hospitals, right up to undergraduate and postgraduate teaching hospitals. Such a 'people's eye view' will also be adopted in the appraisal of some of the national health programmes. It will also be attempted with the urban population, though the data base in this case will be much thinner. These sociological data will be later blended together with administrative, epidemiological, technological and other forms of data to adopt an interdisciplinary systems approach to the appraisal. However, the significant feature here is that the social science data set the pace of the appraisal process.

CHAPTER THREE

ICSSR-ICMR REPORT ON HEALTH FOR ALL: AN ALTERNATIVE STRATEGY

Relatively more space is being devoted to this Report as it forms a major frame of reference for the present appraisal of health policies and programmes in the eighties. The Report has already been referred to while making a comparative study of methologies for appraisal of health policies and programmes. It will be used again in Chapter Thirteen, during discussion of the factors which have shaped the present policies and programmes.

Ivan Illich's critical analysis of the Western system of medicine (Illich 1977; Borremans 1978) stimulated widespread critical examination of and a search for a paradigm for an alternative system for India. The Western system had retained its dominance in independent India, and the effort was not to reject the central scientific core of Western medicine, but to divest it of current cultural and economic accretions which had formed a thick capsule around the central core through extensive iatrogenesis, professionalisation, centralisation and mystification. The example of the 'barefoot doctors' of China gave a further impetus to this line of thinking. It also led to the re-discovery of the recommendations of the Sokhey Committee which had, way back in 1940, made a recommendation similar to that of employment of barefoot doctors, to meet the health service requirements of the rural masses. It may also be pointed out

that even earlier, in 1934, when John Grant (Seipp 1963 : 8) was developing the Department of Hygiene and Public Health in the Peking Union Medical College, he had advocated the use of 'lay' people, selected by rural communities, for carrying out health work.

J.P. Naik was the foremost among Indian scholars who wanted to implement Illich's ideas and transform the health care system of the country. He got an opportunity to give a concrete form to his ideas when, as a member of the Shrivastav Committee (GOI 1975), he persuaded his colleagues to join him in recommending steps which, in effect, led to the initiation of action to shift many decisions concerning health to the people themselves and in this way promote self-reliance. Naik's persistent efforts to promote community self-reliance in health matters received powerful support when, in the wake of the excesses committed during the Emergency of 1975-77, the new government adopted the policy of entrusting the people's health to the people's hands through training community health workers chosen by the people themselves.

To give a more concrete shape to his ideas, J.P. Naik successfully promoted the setting up of the ICSSR-ICMR Study Group on an Alternative Strategy for Health Services in India (ICSSR-ICMR 1981). The Study Group consisted of eminent public health professionals and planners. The major recommendations of this Study Group are summarised below.

Objective: The objective of the national health policy should be to provide health for all by A.D. 2000. This objective cannot be achieved by a linear expansion of the existing system and even by tinkering with it through minor reforms. Nothing short of a radical change is called for; and for this it is necessary to develop a comprehensive national policy on health.

Approach: If this goal is to be realised, a major programme

for the development of health care services is necessary but not sufficient. During the next two decades, therefore, the three programmes of (I) integrated overall development including family planning, (2) improvement in nutrition, environment and health education, and (3) the provision of adequate health care services for all and especially for the poor and underprivileged (through the creation of an alternative model) will have to be pursued side by side.

Integrated Development: The objectives of integrated development are to eliminate poverty and inequality, to spread education, and to enable the poor and under-privileged groups to assert themselves. This will include the following programmes:

1. Rapid economic growth; 2. Full-scale employment; 3. Improvement in the status of women; 4. Adult education with emphasis on health education and vocational skills; 5. Universal elementary education; 6. Welfare of the Scheduled Castes and the Scheduled Tribes; 7. Creation of a democratic, decentralised and participatory form of government; 8. Rural electrification; 9. Improvement in housing; and 10. Organising the poor and underprivileged groups.

Family Planning: There should be a National Population Commission set up by an Act of Parliament to formulate and implement an overall population policy. The objective should be to reduce the net reproduction rate from 1.67 to 1.00 and the birth rate from 33 to 21. While work with women will continue through MCH services, intensive efforts should be made to work with men also. While the health services have a role to play in motivation also, their main responsibility is to supply the needed services and follow-up care. The alternative model of health services has been designed to meet these challenges fully and squarely.

Nutrition: Nutrition will have to be improved through adequate production of food, reduction in post-harvest losses, proper organisation of storage and distribution and increasing

the purchasing power of the poor through generation of employment and organisation of food-for-work programmes.

Improvement of the Environment: Improvement of the environment will reduce infection, make programmes of nutrition more effective, and help materially in reducing morbidity and mortality. Safe drinking water supply will have to be provided to all urban and rural areas. Good sewage disposal systems should be established in all urban areas where, simultaneously, a massive programme of proper collection and disposal of solid wastes and their conversion into compost will have to be developed.

Health Education: Health education should become an integral part of the general education and should receive adequate emphasis. Health education should also be an essential component of all health care; and the health care services should assume special responsibility for the health education of the poor and underprivileged groups who need it most.

Alternative Model of Health Care Services: Within the health sector, the most important recommendation is that the existing exotic, top-down, elite-oriented, urban-biased, centralised and bureaucratic system which over-emphasises the curative aspects, large urban hospitals, doctors and drugs should be replaced by the alternative model of health care services in a planned and phased manner by A.D. 2000. This alternative model is strongly rooted in the community, provides adequate, efficient preventive and curative aspects, and combines the valuable elements in our culture and tradition with the best elements of the Western system. It is also more economic and cost-effective.

Meternal and Child Health (MCH): MCH services should be expanded and improved through an essentially domiciliary programme. The *dais* should be trained and fully utilised.

Communicable Diseases: The fight against communicable

diseases should be continued with still greater vigour. Our object should be to eradicate or at least effectively control diarrhoeal diseases, tetanus, diphatheria, hydrophobia, poliomyelitis, tuberculosis, guneaworm, malaria, filariasis and leprosy.

Training and Manpower: Under the new alternative model, the organisation of the health services will be radically different from that in the existing sytem. A new category of personnel, the Community Health Volunteers, will be introduced and and it will be the main bridge between the community and the services. The middle level personnel will increase very substantially. There should be adequate arrangements for the continuous in-service education of all categories of health personnel. The Government of India should establish, under an Act of Parliament, a Medical and Health Education Commission with comprehensive terms of reference. A continuing study of manpower and training and taking effective action thereon should be a major responsibility of this Commission.

Drugs and Pharmaceuticals: There is need for a clear-cut drug policy and a National Drug Agency to implement it. The pattern of drug production should be oriented to the disease pattern, with an emphasis on the production of basic and essential drugs (especially those needed by the poor and underprivileged groups) which should be produced in adequate quantitites and sold at cheapest possible prices.

Research: The priority areas obviously are primary health care, epidemiology, communicable diseases with a special emphasis on diarrhoea, environmental research, and research on drugs, problems of rural water supply and sanitation, indigenous medicine, health implications of industrial development, and family planning. . It is also necessary to promote research on social aspects of medicine and especially on the economics of health. Considerable attention has to be given to the development of appropriate

technology. Side by side, there should be an emphasis on the development of clinical and basic research, particularly in the field of biology.

Administration: It is necessary to redefine the roles of the central and state governments in view of the large powers delegated to the local bodies at the district level and below. Voluntary agencies will have to function within the overall policy laid down by the state. But they should receive encouragement and aid, especially when struggling at the frontiers and doing pioneering work.

Financial: The total investment in health services should be substantially raised and health expenditure should rise by 8 to 9 per cent per year at constant prices and reach about 6 per cent of GNP by A.D. 2000. The existing priorities should be radically altered and the bulk of the additional resources will have to go into promotive and preventive activities in rural areas, into the development of supportive services like nutrition, sanitation, water supply, and education, and for providing health care services to women and children and the poor and the underprivileged groups.

National Health Service: The alternative model proposed is a large step in the creation of a national health service, but it does not create it. The time is not ripe for it and the issue may be examined, say, ten years from now.

Conditions Essential for Success: The programme suggested to realise the objective of health for all is as exciting and worthwhile as it is realistic and feasible. Its success will depend upon our capacity to create a mass movement and the ranks of millions of young men and women to work it. It will be proportional to the extent to which it is possible (i) to reduce poverty and inequality and spread education; (ii) to organise the poor and underprivileged groups so that they are able to assert themselves; and (iii) to move away from the counter-productive, consumerist Western model of health care and to replace

it by the alternative model based in the community as is proposed in the report.

It may be pointed out that the ICSSR-ICMR Study Group had the advantage of reports of many distinguished committees which had preceded it. The reports of (Shrivastav) Committee on Medical Education and Support, Manpower (GOI 1975), the Community Health Workers' Scheme (GOI 1978) of entrusting of 'peoples' health in people's hands', the Draft National Health Policy of 1977 (GOI 1977), which later culminated in the National Health Policy of 1982 (GOI 1982), the famous Alma Ata Declaration (WHO 1978) and the Planning Commission Report on Population Policy (GOI 1980), all preceded the ICSSR-ICMR Report. Looming farther away in the horizon are the noble principles which guided the deleberations of the Bhore Committee and the nationalist fervour and the social commitment of the Sokhey Committee. In its turn, the ICSSR-ICMR Report provided the basis to the Union Ministry of Health and Family Welfare to draw up a blueprint for action for achieving health for all (GOI 1981b) and for defining the indicators to measure the progress towards that aim. It had also influenced the formulation of the National Health Policy of 1982, which had also accepted t e indicators of the ICSSR-ICMR Study Group for attaining health for all. This document also provided the inspiration for the framing of the 'health' sector of the Sixth and the Seventh Five Year Plans (GOI 1981b; GOI 1985b).

CHAPTER FOUR

THE NATIONAL HEALTH POLICY: AN ANALYSIS

The Government of India's (1982) Statement on National Health Policy reaffirms the government's pledge to fulfil the promises the leadership had made to the people of India half a century back. It painted a very gloomy picture of the then (i.e. 1982) existing situation: the high rate of population growth continued to have an adverse effect on the health and quality of life of the people; distressingly high mortality rates for women and children, with almost one third of the total deaths occuring among people below the age of 5 years and an infant mortality rate of around 126 per thousand live-births; exceptionally high rate of malnutrution; high prevalence of communicable diseases; only 31 per cent of the rural population had access to potable water supply; only 0.5 per cent enjoying basic sanitation: and only 30-35 per cent of the deliveries were conducted by trained birth attendents.

The Statement is quite forthright in analysing the existing situation:

> The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the rural needs of our people and the socio-economic conditions obtaining in the country. The hospital-based, disease and cure-oriented approach towards the establishment of medical services has provided

benefits to the upper crusts of society, specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policy in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

Based on the above contentions, the Statement asserted that the contours of the National Health Policy had to be evolved within a fully integrated planning framework which seeks to provide universal comprehensive primary health care service relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of various health programmes is through the organised involvement and the participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector.

However, as it proceeds further, the Statement mixes policies with programmes. It points out that the revised Twenty Point Programme gives a high priority to the promotion of family planning as a people's programme, on a voluntary basis; it asks for substantial augumentation and provision of primary health care facilities on a universal basis; it calls for control of leprosy, tuberculosis, and blindness; it involves acceleration of welfare programmes for women and children and nutrition programmes for pregnant women, nursing mothers and children, specially in the tribal, hill and backward areas. The Twenty Point Programme also places great emphasis on the supply of drinking water to all problem villages, improvements in the housing and the environment of the weaker sections of society, increased production of essential food items, integrated rural development, spread of universal primary education and expansion of the public distribution system.

Emphasising the importance of population stabilization, the Statement mentioned that a separate National Population Policy was being formulated. Similarly, the need for restructuring of medical and health education had led to efforts to formulate a separate National Medical and Health Education Policy.

To put an end to the (then) existing all round unsatisfactory situation, the Statement underlined the urgent necessity of restructuring the health services around the following broad approaches:

1. To provide a well disbursed network of primary health care services which takes into account the fact that a large majority of health functions can be effectively handled and resolved by the people themselves, with the organised support of volunteers, auxilliaries, paramedics and adequately trained mutipurpose workers of various grades of skill and competence, of both the sexes.

2. Large scale transfer of knowledge, simple skills and technologies to Health Volunteers, selected by the communities and enjoying their confidence.

3. Positive efforts to build up individual self-reliance and effective community participation.

4. Back-up support is provided to primary health care through the establishment of a well worked out referral system at 'the various levels of organisational set-up nearest to the community'.

5. Establishing a nation-wide network of sanitary-cum-epidemiological stations to tackle the entire range of poor health conditions on a wide front.

6. Full utilisation of untapped resources by encouraging the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field.

7. Planned attention to the establishment of centres equipped to provide speciality and super-speciality services through a well disbursed network of centres to meet the present and future requirements for specialist treatment.

8. Special efforts to offer mental health and medical care and physical and social rehabilitation to the disabled.

9. First priority to be accorded to people living in tribal, hill and backward areas and to populations affected by endemic diseases.

The Statement called for development of a 'Health Team' aproach to health manpower development. It also

recommended phasing out of private practice by medical personnel in government services. It advocated involvement of practioners of various systems of medicine with the ultimate objective of bringing about a phased integration of the indigenous and modern systems of medicine.

The Statement also asked for a planned, time-bound attention to some of the more important areas. These were: i) nutrition; ii) prevention of food adultIration and maintenance of the quality of drugs; iii) water supply and sanitation; iv) environmental protection; v) immunization programme; vi) maternal and child health services; vii) school health programme; viii) occupational health services.

The Statement went on to underline the need for health education, management information system, strengthening of the medical industry and development of a statewise health insurance scheme for mobilising additional resources for health promotion and ensuring that the community shared the cost of the services in keeping with its paying capacity.

It asked for a balanced development of basic, clinical and problem-oriented operational research in the field of research. If also emphasised the vital importance of intersectoral cooperation between the health and its more related sectors, with the setting up of suitable mechanisms at the centre and in the states for securing intersectoral coordination in the fields of health and family planning, medical education and research, drugs and pharmaceuticals, food and agriculture, water supply and drainage, housing, education and social welfare and rural development. There was also emphasis on the need for monitoring and review of progress of health programmes.

The Statement ended by setting out the goals for health and family welfare programmes for the years 1985, 1990 and 2000. For the year 2000, it visualized the infant mortality rate to come down from the present 125 to below 60; crude

death rate from around 14 to 9; maternal mortality rate from around 14 to 9; maternal mortality rate from 4-5 to below 2; life expectancy at birth from 52.6 for males and 51.6 for females to 64 for both the sexes; crude birth rate from around 35 to 21; a net reproduction rate from 1.48 to 1.00. It had also set out specific goals for the family size, maternal and child health services including immunisation and for leprosy, tuberculosis and blindness prevention.

Introduction of policy issues of such far reaching significance unwittngly tends to make the numerous weaknesses and inconsistencies in the rest of the Statement all the more glaring and obvious. Surely, the planners and administrators of 1982 could not claim to be qualitatively any different from those who had been associated with development of health services in the past. Furthermore, while such oft-repeated programmes concerning nutrition, prevention of food adultration and maintenace of the quality of drugs, etc. find so much of space in the document, it contains little in the form of policy guidelines to bring about the necessary basic changes in the health administrative systems at various levels to close the cultural gap between the people and providers of health services. What should be the relationship between generalists and specialists in health administration in India? What are the policy guidelines to ensure that the cadre structures, both at the union as well as state levels, are developed in such a way that key positions in community health are filled by managerial physicians, who have the required interdisciplinary competence to adopt an epidemiological approach to extend the outreach of community health services to the unserved and the undeserved? What are the policy guidelines to promote community self-reliance in health? Obviously, the 'above down' health education approach expounded in the Statement is not consistent with promotion of community self-reliance. The Statement has also ignored completely the vital question of regional imbalance in terms of health and health services. For instance, major policy directives are needed to deal with

the alarmingly high mortality and morbidity rates in Uttar Pradesh and Bihar.

Again, at the level of specific programmes, the Statement does not provide any policy frame to overcome the obstacles even in the major health programmes which have been included within the Twenty Point Programme. In the field of medical reseach, the Statement rightly emphasises the need for a 'balanced development of basic, clinical and problem-oriented operational research'. However, what are the policy perspectives for attaining that *balance?* To what extent have findings from problem-oriented operational research contributed to formulation of key community health programmes of the country?

It may be pointed out that way back in 1945-46 the Bhore Committee had taken policy initiatives which were even bolder than those taken in the Statement on National Health Policy: no individual should fail to secure adequate medical care because of inability to pay for it; from the very beginning health programme must lay special emphasis on preventive work; the debt which India owes to the tiller of the soil is immense and although he pays the heaviest toll when femine and pestilence sweep through the land, the medical attention he receives is of one most meagre description — the need is urgent for providing as much medical relief and preventive health care as possible to this group; health services should be placed as close to the people as possible; it is essential to secure the active co-operation of the people in the development of health programmes; the need for the fullest cooperation between health personnel and the people whom they serve is essential; the physican of tomorrow will be a social physician who will protect the people and guide them to a healthier and happier life; health services should be totally integrated, with the specialist health administrators occupying the key positions; finally, health promotion requires an inter-sectoral approach.

Why should the existing conditions be so dismal, despite the policy initiatives taken by the Bhore Committee and the Sokhey Committee more than three and a half decade ago? What led to the adoption of fresh initiatives in the National Health Policy and why is it that along with laudable policy initiatives, the Statement contains so many obviously simplistic assumptions about health services development in India? What will be the future of the Statement on National Health Policy? Will it be followed with a more comprehensive policy statement on health services development in India or will it meet the same fate as the reports of the two Committees referred to above?

Answers to such questions are important for drawing up a strategy for the future — for providing 'Health For All By 2000 A.D. The setting for the present Statement on Health Policy is entirely different. Besides, the authors of the Statement also had the experiance of the Bhore and Sokhey Committees available to them. Probably it is the forces of democratisation which have compelled them to take the bold policy initiatives. However, as the Statement is essentially a concession wrested by the people, it has gone only some way, and not the entire way.

That this has also met the fate of the report of the other two Committees reflects the rate of growth of democratisation in India in the subsequent years. The picture remains gloomy more than seven years after the Parliament had endorsed the policy document. The almost 'wholesale adoption of health manpower development policies and establishment of curative centres based on Western models' continues to be a dominent feature. It continues to be 'hospital-based', serving mainly the 'upper crusts of society' living in urban areas. It also continues to 'enhance dependency' and weaken 'community's capacity to cope with its problems' and 'the cultural gap between the people and the personnel providing health care' remains as wide as ever. The Rural Orientation of Medical Education (ROME)

Programme, which was launched with so much of fanfare, failed to take off.

Implementation of the lofty ideas contained in the policy document required a high level of competence in public health practice. This issue is taken up later in Chapter Seven.

Thus, in sum, despite all the brave policy commitments, an account of the implementation during the past seven years smcks of 'more of the same' discredited, distorted and socially discriminative programmes. Their quantitative expansion can conceivably claim some credit for some modest achievements, e.g., fall in the infant mortality rate from 126 (1980) to 90 in 1986 (GOI 1989a). This provides an apt summing up of the appraisal of health policies and programme in India in the eighties.

CHAPTER FIVE

GAINS IN HEALTH AND HEALTH SERVICES

As pointed out by Gunnar Myrdal (1968:20), the national political leaders in India are all members of the privileged upper class. Their new positions of responsibility and power rapidly invested them with still greater privileges. Many, who had borne heavy burdens or undergone personal sacrifices during the independence struggle, saw in their own advancement a symbol of national political revolution. Conforming to what he has called a 'soft state', these new rulers made lofty egalitarian pronouncements but depended essentially on the machinary bequeathed to them by the British to eusure that the fruits of independence would fall mainly into the laps of this new ruling elite and that their hold on the government will be perpetuated. In contrast to the rural health services, the urban health system continued to receive much greater attention. Public funds were made available to establish a number of hospitals, many of which had the latest, sophisticated equipment for providing intensive care, open heart and brain surgery and cancer therapy services on the model of the industrialised countries. The Western industrialised countries also provided a reference frame for education, training and research. Personnel from these sophisticated, urban based institutions have remained heavily dependent on their counterparts in industialised countries.

However, these considerations should not be allowed to

obscure some significant achievements during the last four decades. Against the background given above, it is all the more remarkable that the masses of people of this country have succeeded in making substantial gains in health and health services. At the time of independence, the conditions were so bad that half of the children born died due to various conditions before they became ten-year old (GOI 1946: 7-10). The maternal death rates were also very high–twenty per thousand live births (National Planning Committee 1948: 20-21). In other words, to have one thousand children alive on their tenth birthdays, the society had to pay in terms of death of forty mothers and one thousand other children. Over and above, there was the colossal cost in terms of death, disability and disease due to widespread prevalance of poverty, hunger and communicable diseases like malaria, tuberculosis, leprosy, filariasis and numerous water-borne infections and infestations (Banerji 1985a: 9-12).

Even though the situation existing to-day is very far from being satisfactory, there have been dramatic improvements over the past four decades. For instance, the maternal death rate and death rates of children below the age of ten is less than one-fourth of the corresponding rates at the time of independence.

However, this should not lead to the conclusion that these dramatic changes have been brought about simply because there has also been improvement in the provision of heath services to the masses of the people of the country. Indeed, a closer examination of the impact of the services provided at various health institutions on the incidence and prevalence rates of the major health problems might reveal that it can account for only a fraction of the decline in the rates. The major impact is due to improvement in the socio-economic conditions and due to biological changes in the host and in the causative agents as a part of the wider ecological changes (McKeown 1976; McDermott 1969). It is interesting to note that in industrialised countries, inspite of

all the developments in medical sciences and expansion of the network of health institutions to make services available and accessible to the people, improvement in the standard of living and possible biological changes in the host and the causative agents are by far the most important factors responsible for the decline in the mortality and morbidity rates (McKeown 1976).

Therefore, the struggle of the masses to gain access to health services is only a part of the wider struggle to improve their health. It may, however, be noted that quite apart from their possible impact on mortality and morbidity rates, health services also perform the important function of alleviating the suffering caused by various types of health problems. Lack of access to health services to get their suffering alleviated often becomes a major cause of distress and anxiety which, in turn, comes in the way of their struggle for health through getting improved standard of living (Banerji 1985a:9).

A Primary Health Centre (PHC) was conceived as an institutional structure to provide integrated preventive, promotive, curative and rehabilitative services for the rural population of the country. This idea was developed as a response of the political leadership of the National Movement to meet the rising aspirations of the masses of the people. The first batch of the PHCs was set up in 1952. Considering the nature of socio-economic relations and the power structure that emerged in India after independence (referred to earlier), it is not surprising that this programme of establishing a network of PHCs all over the country should have encountered so many obstacles. But perhaps it is a much more important fact that, dispite these obstacles, over time there has been a steady growth and development of the network, both in quantitative as well qualitative sense. This, incidentally, provides another instance of how the democratic aspirations of the people could impel the ruling elites to make services available to them.

Quantitatively, there has been significant increase in the number of medical and paramedical persennel in PHCs. Qualitatively, there have been four major changes (Government of India 1987a). First, many special mass campaigns have been integrated with PHCs, both in terms of their staff as well as functions. There have also been national programmes against specific health problems which were developed as integral components of PHCs - tuberculosis, integrated child development and blindness prevention. Second, there has been a functional integration of work of the personnel at PHCs. This has led to the development the categories of male and female multipurpose workers (MPWs). Third, a twenty-five bed hosptial has been developed for every four PHCs in the country. Finally, and perhaps most importantly, a decision was taken by the Government of India in 1977 to entrust 'peoples' health in people's hands' by offering opportunities to village communities to choose from among themselves a person who will work as a Community Health Volunteer (CHV, now called Health Guide) (Government of India 1978). The government authorities also arranged for the training of CHVs, pay them an honorarium and supply some drugs and equipment.

The CHW Scheme was of profound social and political significance. In effect it meant bypassing the entire medical establishment and going directly to the people to strengthen their capacity to cope with their health problems themselves and seek and even demand support from PHCs and other referral health institutions, in case the nature of the health problems so require. Soon after came the historic Declaration of Alma Ata on Primary Health Care (WHO 1978). It called for total coverage of population with comprehansive, integrated health services, which is based on active particpation of the people in the planning, formulation, implementation and evaluation processes. There was to be social control over the health services and that along with health services there would be inter-sectoral action covering fields such as water supply, environmental sanitation, education, women's

development, and employment, to improve the health status of the people.

'Health For All by 2000 A.D. through Primary Health Care' (HFA/PHC-2000) became a catchey and heady slogan of WHO and its Member States. But soon social and political realities overtook HFA/PHC. Slamming down of a highly technicentric programme of Universal Immunization Programme on the people of Third World countries at the instance international organizations like WHO and UNICEF, provides a startling example of such distortion (GOI 1985a). Tragically for the Third World, even otherwise this programme suffers from serious infirmaities from epidemiological, operational and ecological points of view (Banerji 1986a). That such a programme could be forced on the peoples of the Third World gives an awe inspiring demonstration of the power of the ruling elite and their supporters from outside to impose their will on the masses of people.

Nevertheless, despite the many setbacks, the gains during the past decade have been substantial. There is now a firm commitment for a dense network of health services in rural areas: one CHV/Health Guide for 1000 population; a sub-c ntre with a male and a female multipurpose worker for every 5000 population; a PHC for 30,000 people; a Block Health Centre for 100,000 people; and a 25-beded hospital for 100,000 people (GOI 1987a). No other country in the Third World with similar resource constraints can claim to have such an infrastructure of health services for its rural population (Banerji 1985a:422).

There has also been substantial acheivements in developing manpower to meet the requirements of the massive health programmes (Banerji 1985a:73-91). Physicians have been produced in large numbers to serve as health administrators at different levels of the health services. Specialists have also been trained to fulfil the requirements of hospitals and other specialised institutions. Special

efforts were also made to train the required number of teachers, trainers and research workers of various types. In qualitaive terms, a key decision was taken soon after independence to bring about a social orientation of medical education by upgrading the departments of preventive and social medicine in the more than 140 medical colleges in the country.

Urgent steps were also taken to meet the massive manpower needs in nursing. This meant education and training of nurse educators, nurses for hospitals and a vast army of auxilliary nursing personnel, specially auxilliary nurse midwives (ANMs), who were later designated as female multipurpose workers, and their supervisors. The corresponding male multipurpose workers were also provided education and training. The national programmes for malaria, the family planning programme and the vast PHC complexes, each required education and training of more than a hundred thousand paramedical workers. There has been, in addition, education and training of over four hundred thousand Community Health Volunteers/Health Guides. The country can justly be proud of these achievements in developing its health manpower.

CHAPTER SIX

PEOPLE'S FELT NEEDS, HEALTH SERVICES AND COMMODIFICATION OF MEDICINE

FELT NEEDS OF RURAL POPULATION AND THE HEALTH SERVICES:

It must be confessed at the very outset that this is a most venturesome task. Even though it is exciting conceptually, the methodological problems are formidable. It requires data on felt needs. Then there is requirement to have data on the health services which are visited by rural people and the extent to which these meet their felt needs. Furthermore, felt needs, as also the health services, are changing in time. They are also rooted in the complex ecological, socio-cultural, political and economic conditions which, in turn, influence cultural perceptions and cultural meaning of health problems. Over and above, the very meeting of felt needs also brings about changes in health behaviour and in cultural meaning and perceptions. Study of the extent to which the existing health services meet the community felt needs and the consequences of some of the felt needs remaining unmet implies study of a highly complex system that is in a state of constant flux.

As if that is not enough, there are the bewildering

diversities, both in the cultural setting and felt needs and in the nature of the health services in a large country like India. Where are the data on such a large scale? How to get hold of them within the space constraints of this report? Notwithstanding such formidable difficulties, an attempt is still being made below to give an account of the current state of relationship between felt needs in rural populations and the existing heath services, to underline the critical importance of study of the interface between the people and the health services in making an appraisal of health policies and programme in India. Indeed, this chapter forms the centrepiece of the entire report.

The problems concerning the wide range of social, cultural and economic diversities in the country were met by bringing together a wide range of data on health behaviour from different parts of the country. The most significant feature of these data was that, even in most remote regions and in interior tribal populations, there has been an active effort by people–even the poorest sections of the people – to seek assistance from health institutions. In terms of health institutions, it was found that even in the states which occupy top positions in the country in terms of access to health services – like Kerala and Goa – a great deal of felt needs of the rural populations remain unmet. Rapid proliferation of health institutions in the private sector, including the so-called Registered Medical Practioners (RMP)stands testimony to the failure of the government health institutions to meet the felt needs of the people.

From the data concerning felt needs of rural populations from different parts of the country and the degree of response from the corresponding health institutions, which are presented below, it will be apparent that they will cover the situation prevailing in the lower three-fourths of the population of the country, if not more. That will justify adoption of this social science approach to appraisal of health policies and programmes in India.

The idea of studying community felt need for health services germinated from the sociological contributions (Banerji and Andersen 1963) to the formulation of India's National Tuberculosis Programme (NTP) at the National Tuberculosis Institute, (NTI) Bangalore. At a time (1959-63) when the conventional wisdom was that, because of their cultural backwardness, the only way to get hold of tuberculosis cases in a rural community was to embark of an massive (mobile) mass radiography (Sikand and Raj Narain 1957), it was demonstrated that, in Tumkur district (Karnataka) as a whole, as much as three-fourths of tuberculosis patients were 'worried' about the disease and that motivated by their felt need, half of all the cases actually sought assistence at rural health institutions (Banerji and Andersen 1963), where almost all of them were sent back with a bottle of useless cough mixture (Banerji 1971)! One distinguishing feature of the process of formulation of the NTP was to test out the conclusions drawn on the basis of the sociological data in the form of a 'Test Run' phase of an operational research study under the 'live' (not 'pilot') conditions prevailing in the neighbouring Anantapur district (Banerji 1971; Banerji 1972). This test run confirmed the findings that, motivated by the suffering, tuberculosis cases do seek assistance from rural health institutions (and that they can be diagnosed by making sputum examinations).

Many subsequent studies (see, for instance, Pathak 1965; Narayanan et al 1976; Nagpaul et al 1977; Narayanan 1978; Mankodi and van der Veen 1984) have confirmed these findings. Indeed, these findings were proved to be valid throughout the length and breath of the country, where the felt need oriented NTP is being implemented since 1963 (Institute of Communication, Operations Research and Community Involvement - ICORCI 1988).

In the later years there have been many instances of studies – mostly village studies – where health behaviour of rural populations has been studied in relation to a wide

spectum of health problems. Given below are some of the instances.

Djurfeldt and Lindberg (1975) conducted a study of Western medicine in the village Thaiyur in Tamil Nadu in 1969-70 and concluded that as 'the health situation in the village was consequence of the prevailing economic and political order, both the Western and indigenous systems of medicine are equally impotent in dealing with the health situation; and only a profound transformation in the economic and political structure can give the people of Thaiyur the means to improve their health (p.216). In a study of yet another group of Tamil Nadu villages, Sheila Zurbrigg (1984) has looked at continuing ill-health in India through the life of a labouring village woman, exploring the forces which keep her from adequately feeding and caring for her children and herself. She advocates a shift of attention and efforts of health workers to the poverty-dependency-ill-health dynamics, and suggests how issues of ill-health can be used to strengthen the broader struggle by the labouring poor for health and social justice.

Research students at the Centre of Social Medicine and Community Health of Jawaharlal Nehru University have also conducted some significant studies. Studying six Oraon tribal communities living at varying distances from the sophisticated hospital at the steel plant at Rourkela, Santosh Kumar Sahu (1980) had observed that changes in the access to Western medical services had profoundly changed the other components of their health culture. Furthermore, he found considerable degree of unmet felt needs for Western style medical services even in the remotest Oraon villages and that when medical catastrophes strike them, they are prepared to make great sacrifices to gain access to practitioners or institutions of Western medicine.

Studying the interaction between the people and Integrated Child Development Scheme (ICDS) in a tribal block in Orissa,

Santa Raye (1982) observed that many of the major shortcomings in the implementation of the ICDS could have been avoided had the organisers developed a people oriented programme, instead of imposing a pre-determined package of services on the people. She too found considerable unmet felt need for Western medicine in her study population.

Conducting a community study as a component of analysis of the National Leprosy Control Programme (LCP) in Chingleput district of Tamil Nadu as a system, K Venkateswara Rao (1982) found that perception of stigma in a community is confined mostly to those cases who had developed deformities. Cases develop deformities because they are not diagnosed and treated during the long pre-deformity phase of the disease, quite often due to lapses in the implementation of the LCP. Also, carrying out a study of treatment behaviour along the NTI lines, Rao demonstrated that in the case of LCP also, failure of many patients to continue the prescribed treatment are due to inadequate epidemiological analysis in defining a case and to inadequacies in the implementation of the programme.

More recently, Sisir Kumar Sanapati (1987) has reported, on the basis of study of two villages in South 24-Parganas of West Bengal, that villagers, on their own, had sought out various kinds of services from health institutions. These include family planning services and immunization services for mothers and children. Similar trend is discernible in the village studies reported by Sukla Bose (1979) in West Bengal, Victor Jesudian and Meera Chatterjee (1979) in Madhya Pradesh and Duggal et al (1988), Manisha Gupte and Anita Borker (1987) in Maharashtra and M.E. Khan et al (1980) in Uttar Pradesh.

Another source of information on health behaviour has been major surveys, involving many states. This included a multicentric study organized by the Family Planning Foundation (1987), which involved three hilly and five rural

districts of Uttar Pradesh, ten rural and tribal districts of Madhya Pradesh, five tribal districts of Orissa, five districts of Karnataka and ten slums of the Bombay City. Data concerning health behaviour of people are also available from the statewide baseline studies (for detailed list of references, see Annexure 'A') carried out in connection with Area Projects of the Union Department of Family Planning (Banerji 1985a: 87-88). Of particular value are the surveys conducted in two districts of Tamil Nadu by the National Tuberculosis Institute, Bangalore (1988) and in eight districts of Madhya Pradesh by the National Institute of Health and Family Welfare (1985). Another extensive investigation of the NTP involving two districts each from the states of Gujarat, Tamil Nadu, West Bengal, Himachal Pradesh and Manipur, with four purposly selected villages from each one of the states, has also presented a wide range of data concerning health behaviour (ICORCI 1988). Although in many of these studies the issues of health behaviour of the people are discussed only tangentially, the cumulative evidence is overwhelming that in all the very diverse and extensive areas covered in these studies, the suffering caused by health problems has generated considerable felt needs for health services. It can also be safely concluded that a very significant proportion of these felt needs are not met by the government funded health services and that this has generated a thriving medical market in the private sector.

The data provide enough evidence to conclude that, among those who suffer from major illnesses, only a tiny fraction positively reject (Western) health services which are proven to be more effecacious and which are easily available and accessible to them. This is the central finding from the numerous studies cited above. Incidentally, this goes contrary to the earlier studies of health behaviour by social scientists (see, for instance, Carstairs 1955; Marriot 1955). A deeper and much more focussed analysis of this pivotal finding concerning health problems, health behaviour and the role of the government health services in rural areas was made

through a specifically designed, long term study, which is briefly described below.

THE NINETEEN VILLAGE STUDY: THE CONCEPT AND THE DESIGN

The experience from the sociological studies at the National Tuberculosis Institute led in 1972 to conceptualisation of broader based studies of health behaviour of rural populations in India against much wider social and cultural settings (Banerji 1982). This included study of behaviour in relation to a much wider spectrum of health problems, in their curative, preventive and promotive dimensions. Community response to the family planning programme was also included. Another important feature of the reseach design was that study of health behaviour was developed around an integrated concept of the entire way of life in rural populations, which included such key areas as social and biological meaning of poverty, social, economic, demographic and political determinants of poverty, relationship between caste, religion, class and politics and, often based on one or more of these factors, interaction between different segments of a rural community, on the one hand and the different programmes for development, including the 'agents' who deliver the programmes, on the other.

The most significant feature of this study was that the entire methodological edifice was built around such an integrated concept. Depending on the linguistic competence of the investigator, nineteen villages, covering the states of Gujarat, Haryana, Karnataka, Kerala, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal, were selected for a field work type of investigation of health behaviour in the context of the social and cultural setting. To study the influence of access, eleven of the villages chosen also had a fully staffed primary health centre (PHC) and two had a sub-centre of a PHC.

Apart from collecting data through village informants– panchayat members, school teachers and other formal and

informal village leaders – the investigators identified informants and some 'ordinary' members from each segment of the village community and made observations and conducted depth interviews to understand the health culture of the village against the background of its total culture. They also prepared case reports to provide a deeper insight into the response of the different segments to a very wide variety of health problems, covering the fields of medical care, family planning, maternal and child health, communicable diseases, environmental sanitation, etc. Their stay in the villages also enabled them to make direct observations, followed by depth interviews, of the actual behaviour of the villagers when they encountered certain specific health problems. They could also study the interaction between the PHC personnel and the villagers, both when the former visited the village and when the villagers visited the PHC. Apart from these efforts to ensure that in-depth qualitative data were obtained from all the segments of the entire village community and they were, as far as possible, checked and crosschecked, a quantitative dimension was given to the qualitative data by framing an unstructured interview schedule on the basis of these qualitative data and administering it to a stratified random sample (broadly 20 per cent) of the village households.

The study also included a detailed analysis of the organization and functioning of eleven PHCs — interview of individual personnel, collection of performance data, cross-checking of findings concerning community perception of performance of health workers during their village visits and interview of some of the villagers who were actually using the PHC facilities.

Launching of the intensified family planning drive during the Emergency (1975-77) was the immediate stimulus to the decision to revisit to all the villages to assess the community response to the intensified drive. With the very good rapport which had been developed during the first visit, it also became possible to give a time dimension to the findings

observed earlier and to recheck some of the key findings. The data collected through the first revisit turned out to be very valuable. This inspired a number of revisits on similar lines, culminating in a much more extensive collection of data, covering all the nineteen study villages, in 1987-88, to get an integrated account of the socio-cultural, economic, demographic and political changes and changes in health behaviour during the significant period between 1972-1988. This also included collection of quantitative data from similar stratified samples of the households of the nineteen villages. In between, each village had, on an average, four revisits. It may be noted that the period 1972-88 had witnesed major changes in the health services: launching of the Community Health Workers (now Guides) Scheme in 1977; launching of the Area Projects (1980); rapid expansion of the network of rural health services with a sub-centre with a male and a female multipurpose worker for 5000 people, a New PHC or Subsidiary Health Centre for 30,000 and the old PHC being redesignated as a Community Health Centre with 25 beds and staff of medical specialists (from 1980); launching of the Universal Immunization Programme in 1986.

Frequent references will be made to this study in the following pages because the findings have provided the basis for developing a new approach to appraisal of health performance. This approach is basically different from the conventional public health practice and conventional application of social science findings to health fields. The experience of the sixteen-year study has very much become an integral part of the intellectual world of the author. The creation has now become the being.

SOCIO-CULTURAL BACKGROUND OF MEANING AND PERCEPTION OF HEALTH PROBLEMS AND HEALTH BEHAVIOUR:

Compared to urban living, living in villages has major disadvantages. A big city enjoys many social, economic and

political benefits that are not available to a population of corresponding size in rural areas. The dependence of villagers on cities makes them more vulnerable to exploitation and control by city-based political leaders, industrialists, traders, bureaucrats and intellectuals. When, for instance, a person living in a non-PHC village becomes seriously ill, at most he has access to a PHC, situated some ten or fifteen kilometres away, on an average. The PHC facilities being rather limited, often he may have to be taken to a nearby town or city to avail of more sophisticated investigations and treatment. Even when physicians at the PHC are able to handle a patient with reasonable confidence, the relatives might have to rush to the city to get special medicines that might be presecribed by the PHC physicians. For relatives of the patient, this means their having to spend the time, effort and money needed to undertake the journey, interact with people of a different culture and suffer much greater hazards of being cheated by the medicine sellers in terms of price and/or quality of medicine.

In contrast, a well-off city dweller will have relatively easier access to sophisticated medical institutions and good quality medicines with less expense and effort. Significantly, a rickshaw-puller in the same city, though not able to derive the same degree of benefits, enjoys distinct advantages over a villager with the same means.

The same difference applies to all other amenities and opportunities. Villagers have to go to cities for marketing facilities, to get quotas and permits for essential goods from government offices, to look for jobs, to fight out legal battles in higher courts, for entertainment, for higher education, to get transportation and communication facilities, and so on. The focal points which control political activities in rural areas are also located in cities.

Contaminated source of drinking water, dust, dirt and infestations by various kinds of insects and other pests and

parasites, extensive poverty, grossly substandard housing, poor drainage and fecal contamination of the soil and extremely poor personal hygiene, are some of the major features of a village setting. They create an ecological condition highly conducive to widespread prevalence of various kinds of communicable diseases, undernutrition and malnutrition and high rates of morbidity and mortality among children and mothers. Obviously, the health hazards in villages are much greater than what is found in the cities. Also, unlike cities, where the more privileged classes acquire more hygienic living conditions and civic amenities, the gulf in ecological conditions of living between the privileged and the underprivileged classes in villages in much less wide.

The abject dependence of villages on cities and the hazardous conditions of village life have had a profound influence on the culture, including the health culture, of rural populations. This influence is more pronounced amongst the poorer sections in the village. They have to additionally suffer deprivations because they are poor, because they have lower rates of literacy, lower educational levels and because they are abjectly dependent on the richer sections of the village community. This denial of social justice and political rights restricts opportunities and facilities needed to bring about cultural changes and to cope more effectively with various problems. Often, this sheer weight of the prevailing adverse conditions of the poor (just as excess wealth of the rich!) makes them cling to ideas and practices which are patently obscurantist. Thus, the geographical, social, economic and political conditions under which a community lives greatly influence its growth and development. It must be noted that these determinants of culture are quite different from what are generally included under 'culture of poverty' (Valentine 1972; Lewis 1966; Glazer and Moynihan 1963). For a proper understanding of the cultural practices of a community, including its health practices, it is, therefore, necessary to relate its culture to the social, economic and political forces which maintain the ecological settings. In this

study an attempt has been made to adopt this approach.

One of the most striking findings of the study was the extensive prevalence of poverty. Even when it is defined in terms of the basic biological need of hunger satisfaction, as shown in Table - I, there is a very high prevalence poverty and there are wide variations, with some of the villages showing a staggering degree of destitution. Incidentally, it may also be noted that there is no overall change 1988: although it has come down in some villages, it has gone up in others.

In each of the nineteen villages poverty was so pervasive that it did not require any profound sociological or anthropological study to discover it. An outsider to a village would be surrounded by a number of children–many of them unwashed, pale, with expressoionless faces, running noses and sore eyes, as also discoloured hair, dry skin, bulging bellies and emaciated limbs, often suffering from sores and ulcers. Even in the severe winter of north India, their clothing often consists of only a tattered rag or two. Many of them are of school-going age, but have not gone to school. Then there are girls, 5-10 years of age, taking care of younger brothers and sisters while the mother has gone to work.

These children are in fact the battle-scarred 'surviving soldiers' of the grim struggle for existence that begin at birth. And they will have to continue this struggle for the rest of their lives. The struggle actually begins in the womb when the child suffers the consequences of malnutrition in the mother. Birth exposes it to the additional hazards of inadequately attended delivery, the diarrhoeas and bronchopneumonias of infancy and soon after infancy, weanling diarrhoeas. Then come the life-long hazards of communicable diseases—diarrhoeas and dysenteries, enteric fevers, tuberculosis, malaria, leprosy, trachoma, filariasis, tetanus, diphtheria, whooping cough, measles, worm infestations, and so on. The child has also to face a host of other ecology related disorders. If lucky enough to survive all

Table - I *Prevalence of Hunger in 1972 and in 1988*

Sl. No.	Name of the Village	No Satisfaction 1972	1988
1.	Amdanga (W.B)	59.0	74.2
2.	Barajaguli (W.B)	61.3	51.0
3.	Coyalmannam (Kerala)	60.8	46.4
4.	Jadigenhalli (Karnataka)	32.5	40.5
5.	Kachhona (U.P.)	44.9	52.9
6.	Pazhambalakode (Kerala)	86.2	59.8
7.	Pullambadi (Tamil Nadu)	70.1	47.1
8.	Rupal (Gujarat)	22.4	41.2
9.	Rohat (Rajasthan)	25.0	32.5
10.	Rohata (U.P.)	20.7	38.3
11.	Yelwal (Karnataka)	75.0	42.3
12.	Kalur (Karnataka)	88.2	52.4
13.	Arnawali (U.P.)	88.6	41.7
14.	Bilaspur (U.P.)	27.8	46.7
15.	Dakshin Dutta Para (W.B.)	22.2	62.9
16.	Gambhoi (Gujarat)	28.6	30.0
17.	Kamdevpur (W.B.)	40.5	69.1
18.	Rampura (Rajasthan)	33.3	57.1
19.	Sunni (U.P.)	38.9	63.2

these onslaughts, it grows to adulthood and struggles through the rest of its badly battered life almost exactly as its parents did, producing their own progency to continue the cycle of life.

The fact that an overwhelming majority of the population will be called 'poor' if definition of poverty is changed merely to include those who do not get two square *wholesome* meals

all the year round and those who do not have very *elementary* facilities of housing, potable water supply and sanitation, underlines the degree of poverty and deprivation among populations in rural India.

The institution of caste is studied not just within the traditional boundaries of purity and pollution rituals and hierachical positions. It is also studied in terms of class and the forces which determine the class structure of a population. Among the castes, despite pronounced village to village variation, Harijans stand out very sharply as the main victims of caste discrimination by other castes. However, field data have revealed that when purity/pollution rituals come in conflict with class interests, most often the class interests prevail. Interestingly, it is within the Harijans themselves (e.g. Chamars and Bhangis), where there is no conflict of class interests, social discrimination is practised in a much more pronounced manner. The fact that despite twelve decades of proselyting by Catholic missionaries in one of villages (Pullambadi in Tamil Nadu), even the third generation of Catholic converts continue to practise a very rigid form of 'caste' discrimination among themselves, also underlines interplay of factors other than Hindu caste rituals concerning purity and pollution. Again, if caste is responsible for sharp social stratification among Hindus, then one would have expected at least a less pronounced stratification among the Muslims within the study population. This was not found to be the case.

At least compared to Harijans, the non-Harijan and other castes do not suffer as much social discrimination. Among them caste affiliation is used as an instrument for gaining political and economic power.

The highly complicated interaction among various factors which influence economic power, class, caste and religion, also determines the nature of the political system within a population, the leadership structure and the various

mechanisms used for enforcing social and economic control. This interaction forms an equilibrium which is not only dynamic, but also very fragile and unstable. Extensive prevalence of acute poverty, exploitation of one class by another, relentless pressure of rapidly growing population, failure to effectively implement many of the promised social and economic programmes, restiveness within the exploiting groups are some of the major factors which make the equilibrium so unstable and fragile. Frequently this equilibrium is forced to realign itself to changes in the distribution of power within different groups.

Biologically paraphrased, poor people are those who are on the losing side in the struggle for existence. Among those on the losing side are many who have been totally wiped out– they have simply died in their struggle for existence. Those who are not wiped out but somehow manage to cling to their lives, form a significant segment of the poor for many reasons. The most ominous among them is that they have managed to survive under very adverse conditions, earlier considered incompatible with human survival. Due to factors not yet fully understood, it is apparent that the 'floor' for biological survival of a human being has been lowered and because of this he has acquired higher longevity. But survival has become more precarious, and this has drawn these human beings even closer to a vegetative existence. They have become much more vulnerable to manipulation and control by those who have pushed them down in the struggle for existence. And it is only a perpetuation of misery, and not life, when some of the weak children borne by grossly malnourished mothers manage to survive the myriad hazards of life.

The study has thus provided data on various aspects of the most overwhelming health problem faced by rural population in India: the problem of hunger. Poverty also leads to further disintegration and deterioration of the environment and of living conditions–of sanitation, of the

quality of drinking water, of shelter, of clothing and being forced to eat wild roots, grass seeds, leaves and even crumbs thrown in the garbage.

One of the most pernicious and potentially most dangerious consequences of extreme poverty is that it tends to numb the senses of the victims–it is just like the numbness due to destruction of nerves in leprosy. A highly anaemic, grossly malnourished and undernourished woman, who carries all sorts of infections, still thinks she is 'normal', because that is the sort of life she had been living for as long as she remembers. Why, her mother also lived such a life. In a setting such as this, getting enough rice to eat, may be with a piece of fish or meat, is abnormal, or more precisely, a windfall. The children exclaim at the 'sweet' smell of the gluey rice that is boiling in a brimless aluminium pot.

However, quite apart from what can be called 'diseases of poverty', which have become a 'normal' part of their 'normal' lives, diseases also strike them in the form of medical catastrophes, and these strike them more often than they do other groups. Obstruction of childbirth or severe bleeding during childbirth, the husband unable to earn his wage because of prolonged typhoid fever, the adolescent girl constantly crying out in acute agony because of extensive inflamation of the eyes and various forms of serious injuries sustained as a result of accidents or assaults, are examples of such medical catastrophes. Worse still, the poor are in a most disadvantageous position in facing such catastrophes. They are physically weak. Loss of wages due to sickness has profound impact on the economy of the entire household. Besides, they are not articulate–they are illiterate and ill-informed with no money to approach private practitioners or to bribe government officials or to buy the prescribed medicines or meet the cost of transporting the patient to a health institution. They can exercise little 'influence' on officials because they are low down in the power hierarchy of the community. In a desperate bid to avert such catastrophes,

they fall prostrate before the hated landowner or the moneylender or the unscrupulous political boss, and they readily agree to the terms dictated and thus barter away whatever power they possess. This, incidentally, shows how fallacious are assessments of social scientists in ascribing a place for health needs in the hierarchy of needs of the people. When people face no medical catastrophes, health needs may be found low down in the so-called hierarchy of needs; but when there is a medical catastrophe, it becomes not simply a top priority, but a crash priority among the needs of the people. This also provides an example of how fallacies in methodology lead to vital fallacies in the concepts.

Thus, by having control over medical services at the time of medical catastrophes, the exploiting, privileged class uses this as a weapon to control and exploit the poor. Because of its own privileged class-orientation, the medical establishment also ends up strengthening the privileged class by helping the latter to deal more effectively with the (fewer) health problems it has to encounter while, at the same time, it weakens the under-privileged, by denying them access to medical institutions even when they encounter (more frequent) medical catastrophes.

The unequal rural - urban relationship, making the former dependent on the latter, the unfavourable ecological conditions in rural areas, caste and class polarisation leading to exploitation and social injustice, and extensive poverty, which has far reaching influence on the entire way of life of the affected people, all such consideration mould the cultural perception and cultural meaning of health problems and people's response to health services. Furthermore, it would be simplistic to consider these cultural traits as static entities. Through their efforts — or struggle — people seek out new ways of perceiving their health problems and their cultural meaning; along with such changes they also develop better ways of coping with their health problems, by formulating or searching out new health institutions and

changing their health behaviour. This understanding is central to an analysis of health practices of a population.

COMMUNITY RESPONSE TO HEALTH PROBLEMS

One of the principal purposes of the nineteen village study was to find out what *different types of people*, belonging to different classes, castes, occupations, etc. in *different types of villages*, from *different parts of the country*, actually do when they encounter *different types of health problems* and why they do what they do? The different preventive and promotive health measures and efforts to limit the family size also fall within the purview of the study. The many other health behaviour studies, referred to earlier, have also covered many of these areas.

However, for the purpose of the present study, it is not necessary here to discuss in detail all the aspects mentioned above. Only some of the key aspects of the community response which are important for making an appraisal of the rural health services will be briefly discussed below.

Taking into account the social and economic status of the people, the epidemiology of health probelms and the nature of the health services available, it is not surprising that problems of medical care should be by far the most urgent concern among the health problems in rural population. But the surprising finding was that the response to the major medical care problems was very much in favour of the Western (allopathic) system of medicine, irrespective of social economic, occupational and regional consideration. Availability of such services and capacity of patients to meet the expenses were the two major constraining factors.

Apart from these, depending on the economic status of the patient and the gravity of his illness, villagers often sought help from government and non-government medical care agencies in the adjoining (or even distant) towns and cities. There were several instances of families having be

totally ruined in the process of meeting medical care expenses for major illness of the bread-winner or of other family members.

There were numerous instances of adoption of 'traditional' healing practices. But among those who suffered from major illness, only a very tiny fraction preferentially adopted these practices, by positively rejecting facilities of the Western system of medicine which are more efficacious and which were easily available and accessible to them. Usually these practices and home remedies were adopted: (i) side by side with Western medicine; (ii) after Western medicines failed to give benefits; (iii) when Western medical services were not available or accessible to them due to various reasons; and, (iv) frequently, when the illness was of minor nature.

Another very significant finding of this study was that there was considerable unmet felt need for the services of the Auxiliary Nurse Midwife (ANM) at the time of childbirth. Villagers were keen to have the ANM's service because they considered her to be more skilled than the traditional *dai*. Wherever the ANMs have provided services, the *dai's* role had become less significant. The overall image of the ANM/LHV in villages in north India was that of a person who is quite distant from them–meant only for special people or for those who can pay for her services. She is not for the poor. She can be called only when there are complications and then also she should be paid. She is not expected to visit them during pregnancy or after delivery. In the villages in the south, the position is (only) relatively better, though there also the utilisation of the ANM is much below the optimal level, thus leaving substantial unmet felt needs. Antenatal and postanatal care of mothers, as well as care of the children are virtually absent even in the villages in which PHCs have been functioning for a very long time. Lady doctors, whenever available, are even more inaccessible than the LHVs and ANMs. The villagers actively seek their help or even take the patients to the city hospital in the case of intractable obstetrical

complications. These data once again belie the prevailing notion that the illiterate, superstitious and ignorant villagers do not accept offers of scientific health care services and, instead, they go for primitive health practices. *Dais*, relatives and neighbours conduct the majority of the deliveries even in the villages where a PHC is located. In the villages with no PHC, their sway is almost complete. It is noteworthy that the *Dais* seek help from the ANM, LHV or the lady doctor for complications which they are unable to manage. Use of unclean instruments and adoption of cruder methods by the *Dais* and relatives and neighbours can be held responsible for the much more frequent occurrence of neonatal tetanus and other complications. But, in contrast with the ANM and LHV, they either don't cost anything or their charges are moderate; they are easily available and accessible at any hour of the day; they readily pay repeated visits to the mother during the pregnancy, labour and after labour; they perform such chores as massaging of the mother, looking after the infant, washing the clothes and disposing of the placenta and other soiled material; and, above all, being an useful integral part of village social system, they inspire confidence among the villagers and, unlike the ANMs and LHVs, they do not subdue them by their curt or even rude behaviour ('cultural gap'). Confinement by relatives and friends and the indigenous *Dais* is popular among the villagers not because of their intrinsic merits: but in the absence of suitable services from the ANM/LHV/lady doctors, they are compelled to settle for something which they consider to be inferior but which is all that is available accessible to them.

Malaria and smallpox were the two programmes which can be stated to have attained some success in reaching the grass roots. Despite several complaints regarding the sincerity of these workers, there was almost universal agreement among the villagers that these workers did visit the community–they reached people in their homes. It is, however, interesting that frequently the villagers did not associate them with the PHC.

Except when there are understandable compulsions, such as the prospect of the poverty-stricken mother losing wages for 4-5 days at the peak agricultural season due to the child's vaccination reactions and some cases of orthodoxy, there was general acceptance of smallpox vaccination in village communities. The number of children who were left unvaccinated due to lapses of the parents appeared to be a very small fraction of those who remained unvaccinated due to the lapses of the vaccinators and their supervisors. During the outbreak of smallpox in a village where the study was going on, the organisation was seen to react very sluggishly, both in terms of getting the information and in terms of taking preventive measures. Also, finding little to choose between treatment of the smallpox case by Western methods and depending on the goddess Sitala for the survival, villagers adopted a mixture of both these practices.

Patients suffering from tuberculosis and trachoma got very little benefit from the corresponding national programmes. They were forced to seek help from elsewhere. Such help was not only much more expensive and bothersome, but it was also much less efficacious, both clinically as well as epidemiologically. Other preventive measures were almost non-existent.

There were no sustained efforts to deal with such diseases as cholera, diphtheria and guineaworm and hookworm infestations as public health problems. When, however, epidemics of cholera and diphtheria struck separately three of the study villages when the field work was going on, the PHC and the district health authorities encountered little difficulty in getting community participation in the anti-epidemic measures. There were also instances of villagers, on their own, seeking triple antigen immunisation from the PHC. Very often even this need was not met by the PHC.

This finding was reinforced by the experience of community participation in the Universal Immunisation Programme

(1986-90). Even though as many as 47 deaths have been reported from some of the states during 1987 of 1988, there have been frequent cases of abcess formation due to injection and there have been numerous cases complications, there was little resistance of the comminity to immunisation (Gupta and Murali 1989: 116-17; Banerji 1989b)

Although, by far the great majority of the villagers still go to the fields for defecation, significantly, impelled by sheer felt need, a number of them have incurred considerable expenditure to get latrines of various types installed in their homes. They got little help in any form from the PHC. Availability or otherwise of different types of latrines in different villages during 1972-74 is compared with the situation existing in 1988 in Table-II. Though the situation has remained virtually unchanged in some villages, in many others there is a significant increase in the installation of sanitary latrines. This reflects different levels of 'development'.

The family planning programme had ended up in projecting an image which is just the opposite of what was actually intended. Instead of projecting an image which relfects respect for dignity of the individual–the so-called democratic approach which offers free choice of methods to the users and which ensures better health service–the image of the family planning workers in rural areas was that of persons who use coercion and other kinds of pressure tactics and offer bribes to entice people to accept vasectomy or tubectomy. To a large section of the villagers, the workers behind the banner of the inverted red triangle invoked a feeling of strong antipathy.

There have been numerous complaints from the villagers that they got no help from the organisation when they encountered complications following acceptance of family planning service – IUCD, vasectomy and tubectomy. These dissatisfied acceptors have been allowed to freely spread scare stories regarding these methods. Failure to provide even a very rudimentary system of health services, particularly

curative services, had tended to reinforce this negative image.

Table - II *Availability of Latrines in 1972 and in 1988*

Sl.No.	Name of the Village	None		Scavenging		Flush/ Sanitary		Borehole	
		1972	1988	1972	1988	1972	1988	1972	1988
1.	Amdanga	87.2	82.3	5.1	6.5	2.6	1.6	5.1	9.7
2.	Barajaguli	55.0	30.0	26.3	7.0	8.8	28.0	10.0	35.0
3.	Coyalmannam	90.0	50.0	10.0	15.3	0.0	32.7	0.0	2.0
4.	Jadigenhalli	90.0	85.7	0.0	0.0	1.3	2.4	8.8	11.9
5.	Kachhona	77.1	64.3	21.3	18.6	1.4	11.3	0.0	12.9
6.	Pazhambalakode	89.5	68.6	8.8	1.0	1.8	25.5	00.0	5.9
7.	Pullambadi	92.8	90.8	7.2	0.0	0.0	9.2	0.0	0.0
8.	Rupal	96.5	92.6	0.0	0.0	3.5	0.0	0.0	7.4
9.	Rohat	97.2	92.5	2.8	2.5	0.0	1.3	0.0	3.8
10.	Rohata	82.2	84.0	7.8	7.4	7.8	2.5	2.2	6:2
11.	Yelwal	85.5	59.6	0.0	32.7	14.6	0.0	0.0	7.7
12.	Kalur	100.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0
13.	Arnawali	97.4	98.3	2.6	1.7	0.0	0.0	0.0	0.0
14.	Bilaspur	94.4	100.0	5.6	0.0	0.0	0.0	0.0	0.0
15.	Dakshin Dutta Para	96.3	87.1	3.7	0.0	0.0	10.0	0.0	2.9
16.	Gambhoi	100.0	92.5	0.0	0.0	0.0	0.0	0.0	7.5
17.	Kamdevpur	97.2	61.8	0.0	1.8	2.4	3.6	4.9	32.7
18.	Rampura	100.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0
19.	Sunni	97.2	100.0	2.8	0.0	0.0	0.0	0.0	0.0

Because of failure of workers to develop rapport with the villagers, sometimes the villagers were unable to meet their needs for family planning services. Negative response invoked by the high handed attitude of the family planning workers and the single method mass approach usually adopted by them often obscured the fact that many villagers actively sought family planning methods of their choice and these demands remained mostly unmet due to lack of response from the field workers.

There were several instances of mothers, who, failing to get suitable family planning services from the PHC, took recourse to induced abortions from grossly incompetent rackteers, who work under very unhygienic conditions, to get rid of unwanted pregnancies. This not only points to the failure of the programme to meet their needs for the services but it also draws attention to the failure of the programme to offer suitable abortion services to mothers with unwanted pregnancies, despite the passage of the abortion bill.

Most of the Nirodh users had to get their supply from the commercial channels. The depot holders were virtually non-existent and the free supply from PHC, according to some villagers, often found its way into the market and is sold through the commercial channel.

It may, however, be pointed out that the negative attitude of the people was more against the family planning workers, rather than towards the need to limit the family size. There have been numerous instances of persons voluntarily coming forward to have various means of family limitation. Ironically, once again, because of unimaginative design of the programme and its clumsier implementation, it has not been possible to meet the felt needs of the people for family limitation, despite almost exponential growth of allocations in the successive Five Year Plans.

COMMODIFICATION OF MEDICAL AND OTHER SERVICES

A pronounced imbalance between felt needs and the access of people to government health institutions to meet those felt needs had generated a substantial market for the private sector. An interesting feature of this private sector was that it had taken note of the low purchasing power of the people and their social, cultural and occupational norms in responding to their felt needs. The formation of the so-called Registered Medical Practitioner (RMP) is one of the outcomes of this situation.

On the whole, the government dispensary projected a very unflattering image. Discrimination against the poor and the oppressed, poor quality of medicines (only red water), lack of medicines, over-crowding and long wait, nepotism, bribery and indifferent and often rude behaviour of the staff were some of the charges that had been levelled against most of the dispensaries. Complaints about medicines and over-crowding and long wait are made even against the best of the PHCs studied.

Because of the very poor image of the PHC dispensary and its limited capacity, it is unable to satisfy a very substantial proportion of the demand of the villagers for medical care services. This enormous unmet felt need for medical care services is the main motive force in the creation of a very large number of RMPs or 'quacks'. The RMPs are thus in effect created as a result of the inability of the PHC dispensary or other qualified medical practitioners to meet the demands for medical care services in villages.

The RMPs form the overwhelmingly large bulk of practioners of Western medicine in rural areas. They are of widely varying quality. Some of them just picked up a few medical ideas from wherever they could and built themselves up through 'trial and error' and through their long 'experience'. At the other extreme are RMPs who had long stints with

qualified physicians, in government or private institutions, usually serving as pharmacists. They had acquired enough of confidence to 'treat patients as effectively as doctors'. Besides, RMPs are better salesmen. Their behaviour is good, they are available in times that suit their clients, they agree to deferred payment: in short, they are one of them. In this case, there is little of the cultural gap that is talked so loudly in the National Health Policy. Besides, though some mishaps are inevitable, they have learnt to refer the more difficult cases to more 'competent' people. The fact that there is such a wide range and varieties of RMPs shows how simplistic, uninformed and unimaginative had been the fond hopes of the Union Government to 'register' such 'quacks' to control their numbers, with a view eradicating this 'menace', once for all. They had overlooked almost entirely the social, economic and technologial bases of formation of RMPs. In their crusading zeal they also overlooked the fact many of medical professionals who carry the licence to practise, also frequently indulge in grossly unethical and unscientific practices which are not very different than those of the much maligned RMPs (Government of Maharashtra 1986). The fact that the RMPs exist and flourish is actually an indictment of the so-called qualified medical practioners and the medical profession of the country. The RMPs serve a 'social purpose' of demystification, deprofessionalisation and decentralisation of the medical practices and the profession's concerted effort to appropriate the health of the people!

Besides the RMPs, there are several other varieties of medical practioners—vaids, hakims, bonesetters, midwives, faith healers of various kinds, and so forth. Some of them have become very popular : an unqualified homeopath has a thriving practice and a nursing home at Coyalmannam (Palghat district); a hereditory group of hakims is still respected by the people of Rohta (Meerut); a faith healer in Kamdevpur (Nadia) has a palatial establishment and he attracts many affluent clients from far and wide, the bulk of them being from

Calcutta. Interstingly, the people for Kamdevpur themselves do not have much 'faith' in that healer!

However, taken as a whole, the role of the different kinds of healers is limited. Often, in bid to get clients, many of them use injections and allopathic medicines, to 'compete' with the RMPs. Moreover, the formal educational standards in ayurveda, unani and homeopathy are not very high or even standardised. Because of this the degree of professionalisation and mystification is much lower than what obtains in Western medicine.

Over and above, there are virtually infinite varieties of home remedies and practices. In this context, the term, 'Medical Pleuralism' becomes almost redundant. Is it possible to conceive of 'medical singularism' even in the most 'advanced', 'affluent' and 'modern' culture?

The cardinal capitalistic traits of competition and market have also stimulated qualified practioners of Western medicine to set up medical practice in rural areas. Almost all PHC villages had one or more of such qualified practioners, each with his own drug store. The more enterprising among them have acquired mobility to cover the surrounding villages by becoming a 'Motor Cycle Doctor'! Incidentally, the lowly RMPs and other forms of practioners have also become mobile – the poorer among them using bicycles, while the more successful among them move about in motor cycles. The village Barajaguli has now become so prosperous that it has attracted more than half dozen of MBBS practising physicians from the nearby (10 km) Kalyani town to make a daily journey to the village to attend their 'chambers' during fixed hours. Clinical and radiological diagnostic laboratories have also been set up in Barajaguli. Eleswhere, at many places, enterpreneurs have set up small maternity homes and nursing homes. There is, in addition, a big missionary hospital — the Sahayamata Hospital — at Pullambadi in Trichy district and a small one at Coyalmannam.

Studying health behaviour in two villages in South 24 - Parganas district, Senapati (1987) has pointed out that with the nearby government Subsideriary Health Centre, and the PHC some five kilometers away working at a very low level of efflciency, even the poorer sections of the population look to RMPs for medical care services, including tetanus toxoid injections for pregnant mothers. They go to the private practioners or to the nursing home in the nearby town for more serious ailments. Incidentally, this town also has an 'unauthorised' nursing home which specialises in conducting abortions. For still more serious conditions, they take the bus at Diamond Harbour Road to go straight to the Chittaranjan Hospital at Calcutta.

The market forces have also attracted the functionaries of government health institutions. To many of those physicians, who are allowed private practice by the respective state government; private practice has become their primary function, with the PHC or the Subsidiary Health Centre often serving as convenient instruments to boost their private practice. With the physicians giving the lead, some other categories of workers have also carved places for themselves in the market. The pharmacists and the ANMs are the most prominent groups. Many of the ANMs are the most prominent groups. Many of the ANMs have now well established themselves and payment for conducting deliveries has become almost the rule. Some of them have even developed a thriving practice in conducting illegal abortions!

Thus, it can be concluded that despite the very limited purchasing power, inadequacies in the government health institutions have led to rapid increase in the market for the medical care commodity. People are forced to pay, because often it is a question of suffering or even that of life and death to themselves or to their dear and near ones. A host of medical peddlers have cropped up to exploit this increasing market based on human suffering, disability and death. They, all of them, have now developed a sort of vested interest

in the inefficiency of the government health service system to ensure that they can make profits by grabbing as big a slice of the market as they can. The moot point is: will the people allow themselves to be thus exploited and that the health service system will continue to be so grossly inefficient and corruption ridden? This is a social and political question of profound significance for growth and development of health services in India.

SOME TENTATIVE OBSERVATIONS ON THE DYNAMICS OF INTERACTIONS OF SOCIO-CULTURAL AND POLITICAL FORCES, POPULATION SIZE, HEALTH BEHAVIOUR AND HEALTH INSTITUTIONS DURING 1972-1988.

Organisation, analysis and interpretation of the very large volume of qualitative and quantitative data collected over a time span of sixteen years needs very great efforts. A report entitled: *Poverty, Class and Health Culture in India* (Banerji 1982) was prepared, mainly to present, in the time perspective of 1972-1981, an account of socio-cultural, economic and political changes in the study villages and their broad linkages with health behaviour and with government-run health services and other health institutions. Much more work remains to be done before a commprehensive report of the entire study, covering the time span of sixteen years, is finalised. However, as this study is of considerable relevance to the present appraisal, some of the major findings from the first visit, along with the trend of changes in the social setting and in the health behaviour of the same population over a sixteen year period, are presented below as a preliminary communication on the research.

During the first visit, there was extensive prevalence of poverty and hunger. There was virtually no potable water supplt in any of the villages. The environmental sanitation

and housing conditions were very bad. Nevertheless, in spite of the very degrading conditions of living for the bulk of the population in these villages, some efforts have been made, even at that time, to 'develop' them. Besides, many persons who were relatively well-off had brought about changes in the economic setting through their own efforts.

These changes were manifested in the form of development of roads, transport system, electrification, post and telegraph and telephone communication facilities, use of radios and a few television sets, expansion of the education system, opening of branches of commercial banks, formation of co-operatives, modernisation of agriculture in the form of use of chemical fetilisers and pesticides, high-yielding varieties of seeds, irrigation pumps, tractors, etc., shopping facilities, markets for sale of agricultural produce, small repair shops, setting up of industries of various kinds, and so forth.

By that time there had also been considerable expansion of the government-run rural health services, doing curative, preventive, promotive and family planning work. Significantly, there had also been a major expansion of the 'private sector' in the curative fields in the form of medical practitioners of various kinds, chemist shops and maternity homes and nursing homes. There have also been some growth of political institutions in the form of panchayat organisations, with political parties showing growing interest in elections to various bodies.

Even from a preliminary analysis and interpretation of the very limited data on the changes that have taken place over a period of sixteen years, it is possible to come to some very broad conclusions about rural social transformation and changes in health behaviour. While arriving at these conclusions, it was constantly kept in mind that this period of sixteen years has included some major upheavals in the country in social and political fields. It is also realised that the study villages were also very different from one another,

both from socio-economic and health behaviour points of view, as they belong to eight different states and as some of them also happen to be block administrative headquarters with PHC located in them. Besides, during this period there have been several efforts at mobilisation of the voters for the many elections that have taken place for gram panchayats, panchayat samitis, zilla parishads, state legislatures and the Lok Sabha.

One overwhelming finding at the end of about sixteen years since the study was started is a more than 50 per cent increase in the total population of the villages. What is more significant, this population growth has not taken place evenly in all the villages. As given in the Table - III, Amdanga has actually shown a decrease in population; in five other villages, the growth has been about half or less than the overall average. At the other extreme, Barajaguli has registered a population growth of 325 per cent, in another three the range of the growth is from 93 to 140 per cent.

An equally remarkable finding of this study is that even this massive overall growth of the population in the villages has not confirmed the simplistic predictions made by Malthus and his present day diciples. The growth has undoubtedly been exponential at rates of more than two per cent per annum. But this has not led to the famines, wars and epidemics, as predicted by Malthus. An explanation for this phenomenon can found in the pronounced social and political changes that have taken place in these villages during the same period.

Perhaps the most remarkable finding from this study is the significant growth in the momentum of the democratic movement within the study population. It may be pointed out immediately that this momentum is being visualised in a relative sense. A very long way is yet to be covered before the people in the villages are able to actively participate in the decisions which concern them. However, starting from the

Table - III *Growth of Population in the Study Villages (1972-1988)*

Sl.No.	Village	1971/72	1987/88	Percent Change
1.	Amdanga	1724	1431	-17.0
2.	Kamdevpur	1687	1906	13.0
3.	Pazhambalakode	5592	4272	18.9
4.	Coyalmannam	3012	3700	22.8
5.	Pullambadi	6026	7511	24.6
6.	Jadigenhalli	1163	1488	27.9
7.	Kalur	572	754	31.8
8.	Bilaspur	557	767	37.7
9.	Rupal	1710	2578	50.3
10.	Rohata	7009	10546	50.5
11.	Arnavali	1772	2678	51.1
12.	Dakshin Dutta Para	661	1105	67.2
13.	Rohat	2459	4280	74.1
14.	Kachhona	2289	4048	76.9
15.	Yelwal	1608	2858	77.7
16.	Sunni	928	1795	93.4
17.	Rampura	534	1035	93.8
18.	Gambhoi	500	1200	140.0
19.	Barajaguli	1128	4800	325.5
	Total	38931	58744	50.9

democratic movement during the freedom struggle, there has been a sustained progress since independence. The situation existing between 1972-1981 has been described in considerable detail in *Poverty, Class and Health Culture.* The subsequent years have revealed a further increase in the political conciousness among the masses.

Another interesting feature of the changes that have taken place during the past decade and half is the rapid development of the system of communication and transportation between the villages and the world outside. This is in the form of very rapid increase in the number of the radio sets. There has also been a remarkable increase in the number of television sets in the villages. The villagers also use telephones more frequently. There is also a sharp increase in travel by road to the nearby towns and to the state capital. This change in the village population is a part of the wider political changes that have taken place at the block, district, state and national levels.

There has also been a sharp rise in the interest of the villagers in the affairs of the panchayats. In many villages there is also active participation in the co-operative movement. The Rural Employment Scheme has also generated some confidence among the oppressed sections of the population in such villages.

Concurrent with the very heartening developments among the masses of the people, the follow up studies have also shown that there has been a rapid increase in the polarisation between privileged classes, castes and other sectional interests, and the rest of the population. It is this interaction of the interests of the increasingly powerful class and castes and other groups and those of the masses of the people which has shaped the pattern of the remarkable social transformation and the remarkable changes in the health behaviour that have been observed in this study.

The initial round of the study had revealed extensive

prevalence of poverty and human degradation in many of the villages. The past sixteen years have shown significant changes. In some of the villages the changes are for the better; in others it is for the worse. However, taken as a whole, the situation has remained more or less the same, despite the rapid increase in the total population. Table - I (p 55) gives the details.

The general conditions in the villages as a whole have certainly registered very significant improvements. As pointed out above, there are remarkable improvements in the development and use of communication and transportation systems. There is also a very rapid expansion of the government sponsored credit and banking system. The public distribution system for providing foodgrains and other essential items at fair prices has also expanded rapidly. There has been rapid increase in the use of tractors, irrigation pumps and chemical fertilisers. Many more villages have been electrified and many more houses have availed of power connections. Notable changes have taken place in terms of water supply, nutritional services and housing conditions. Marketing facilities have grown and enterprising villagers have availed of the communication and transportation facilities to reach markets far beyond the traditional marketing system they have been using earlier. There is also a significant increase in the local economic and employment generating activities of various kinds. There is very large increase in the types of goods available in the villages themselves. There are also a number of repair shops to service the many modern gadgets and tools that are being used within the villages. Establishment of bigger industrial ventures near some of the villages (e.g. a textile mill or a dairy farm) has spurred economic activities in these villages. Increasing affluence of some of the villagers has also created a larger market for entertainment establishments, such as cinemas and theatres.

Another remarkable change is in the form of rapid expansion of the rural health service system. From the

earlier pattern of having one primary health centre and ten sub-centres for a population of 1,00,000, as pointed out earlier, steps have already been initiated to have one primary health centre for a population of 30,000 and a sub-centre with a male and female worker for a population of 5,000, with the old primary health centre being redesignated as the community/block health centre. The latter is expected to have a bed strength of 25-30, with specialists in four clinical areas. A still more remarkable feature of this process of expansion was the government commitment, in the wake of the political upheaval in 1977, to entrust 'people's health in people's hands' by allowing them to choose a community health worker (CHV) from among the villagers themselves for every 1,000 population, so that the villagers can acquire the power to cope with their own health problems, as far as possible. This scheme also visualised that the villager will use the CHVs to demand assistance from the rest of the health services system, when their health problems need competence of a higher order.

Many of the above decisions, taken more than a decade back, have not been implemented in many of the PHCs in the study area. Worse still, there has been a further sharp decline in the efficiency of the rural health services. Corruption among the health workers has become more rampant and blatant. The formation and the functioning of the health services in rural areas very aptly reflect the two opposite forces that are at work in Indian society at large, referred earlier. At one end is the increasing democratic aspirations among the masses of the people of the country, which have impelled the political leadership to concede more and more resources to the rural sector. At the other extreme is the class character of the political and administrative decision makers, which is responsible for the sharp deterioration in the quality of the services provided. When seen against the nature of the power structure in the study villages (Banerji 1982), it was quite apparent the people's health simply could not be placed in people's hands as the community health workers 'chosen'

by the village community do not reflect the aspirations of the rural people, least of all those of the poor and the oppressed.

Along with the widespread cultural, social, political and economic changes that have taken place in the study villages, there has been a very significant change in the health behaviour of the population. As mentioned earlier, felt needs among the people for getting (allopathic) medical services to alleviate the suffering caused by the various health problems has now increased even more rapidly. It was observed, however, that even those who could get the money to seek medical services from the private sector, both within the village and outside, did not get very satisfactory results.

This was very clearly exemplified by the cases of tuberculosis in the study villages. A felt-need oriented national tuberculosis programme has been in operation in the country since the early sixties (Banerji 1977). However, it was observed that the programme was not being implemented adequately in any of the eleven PHCs studied. In fact, the programme has suffered because of the decline in the quality of the services over the period. One consequence of this decline is the creation of market in the private sector. The private sector has gleefully 'caught' the tuberculosis cases and extracted money from the victims for various therapeutic and diagnostic services, which are often neither scientifically justifiable nor ethically sound (Mankodi and van der Veen 1985). The unfortunate victims are left to their fate once they exhausted all sources of getting the money to meet the heavy expenses for their treatment. The result of this state of affairs is that during the last visit to the study villages it was observed that there were a large number of incompletely treated tuberculosis cases, who could no longer afford to continue to pay for their treatment (Banerji 1988). Similar observations have been recorded by Sahu (1980), Jadhav (1988) and Qadeer (1985).

Thus, while there has been a steep increase in the felt

need and demand for medical care services within the study population, these have not been adequately catered to, either by the government health institutions or by the private sector. This stituation is extremely unstable.

PEOPLE'S EYE VIEW OF THE HEALTH INSTITUTIONS

This is considered to be by far the most critical criterion for appraisal of health programmes. After all, the community health services are meant for the community. This interface between the people and the health institutions which are meant to serve them is being examind against the background of (a) socio-cultural and economic setting and the latter's relevance to the formation of cultural meaning and perception of health problems; (b) socio-cultural response to the health problems; (c) other institutions available in the community to cope with the health problems; and, (d) finally, examine how all these related factors have been changing with passage of time. Such a 'below up' approach to appraisal will be related to an 'above down' one in the subsequent six chapters.

It may be recalled that the National Health Policy had two major planks. One was to visualise purposive intervention in the existing health culture of the people and the other was to underline that such interventions were to be made to promote self-reliance and to enable people to more effectively cope with their health problems, on their own. The criteria for policy implementation were to find alternatives to the Western models of manpower development and of institutions. The most important requisite for this is to bridge the 'cultural gap' between the providers of the services and the people. From the preceding sections concerning the people, *it can safely be concluded that, despite all the efforts of the past, not much headway has been made in meeting the criteria set out in the National Health Policy; if anything, there might have been a further slide back.* What to speak of purposive action, with full community involvement and intersectoral action to improve the health status of the people of the country, even

the most elementary task of alleviating the suffering of those who are actively seeking routine curative services at various health institutions is not being performed well. The 'cultural gap' remains as wide as ever. However, it may also be noted that a large number of persons would have suffered much greater hardship, if, hypothetically, these institutions did not exist at all. The moot point is the degree to which they respond to the felt needs of the people and the degree to which they succeed in creating conditions which stimulate more favourable growth of the health culture of the people.

Community Health Guides

Taken at its face value, it was step of far reaching importance in the democratisation of the health services—increasing the capacity of the people to cope with their health problems, providing support in curative, preventive and promotive fields, playing the advocacy role for the people to ensure that they get what is their due from the health institutions, and so forth. It did not need much foresight to predict (Banerji 1978) that the socio-cultural and political setting, since its very inception, had not been propitious for effective implementation of such an ambitious experimentation in democratisation of the rural health services. Some earlier evalution studies had indicated some very modest progress (Bose et al 1983; NIHFW 1978; NIHFW 1979). However, in the subsequent years, the powerful socio-cultural and political forces have swept aside even the very modest expectations from the programme. As far as the people are concerned, the programme has virtually ceased to exist. Indeed, at one stage the Union Ministry of Health and Family Welfare had decided to formally abandon the programme (Bose 1988: 488). However, this was reversed, considering the sensitive social and political remifications of such a decision. Instead, the programme is allowed simply to wither away by denying it funds and supplies and almost abondoning the training of the health guides.

Primary Health Centre Complex

It may be emphasised once again that, considering the very wide variations in different parts of the country, response of PHCs to people's felt needs is being discussed only in very broad terms and these would be mostly relevant to, say, 85 percent or more of the rural population and a similar proportion of PHCs.

The PHC complex consists of the old PHC headquerters with bed strengths ranging from 6 to as many as 25 or 50; at some places these beds are dieted with provisions for nursing and other staff. They are in the process of transition to become Community or Block Health Centres. There are also one or more Subsidiary Health Centres with a few (usually non-dieted) beds, which are in the process of being redsignated as New PHCs. Then there are some twenty sub-centres, either with buildings of their own or in rented quarters, with a male and a female (ANMs) multipurpose workers (MPWs).

Medical Care Services: Although the PHC complex is assigned a wide range of functions, covering curative, preventive, promotive and family planning activites, the curative activities dominate its day-to-day functions. For the people too, considering the ecological and socio-economic setting, seeking cure for various forms of diseases form by far the most dominant component of their felt need for health services. That there is an extensive and flourishing market for private sector for medical care testifies to the gross quantitative and qualitative inadequacies even in the curative services offered by the PHC. The nineteen village study reveals numerous cases of gross professional misconduct, callousness, negligence and sheer incompetence of the staff, leading to avoidable death, disability and suffering. The patients are made to wait for long periods; behaviour of the staff is rude and insulting, apart from having a wide cultural gap in communication and intereaction. Overcrowding, grossly unhygienic conditions, shortage of drugs, rampant

corruption and nepotism are the hallmarks of many of the outpatient departments of PHCs (Banerji 1989b)

Nevertheless, the fact that, notwithstanding all the indignities, inconvenience, loss of wages and other expenses, patients throng at PHCs to seek relief, reflects the helplessness of a large section of the rural population, particularly of the poorer sections. It also provides an eloquent example of the degree of the failure of PHCs to fulfil one of its basic obligations to the people.

A PHC, located at the Grand Trunk Road of Bardhaman district of West Bengal, serving a population of over 150,000, provides a typical case. The outpatient section was jam packed with sick women and children and men. The day was hot and humid and the place was dark and dingy with swarms of flies, mosquitoes and other insects; stray dogs and cattle walked right into the inpatient section. The roofs leaked and the toilets stank. There were no facilities for even drinking water for the patients. The lone physician had graduated only five years back. He was thoroughly dissatisfied with his position. He was making desperate efforts to get posted at Calcutta, so that he can pursue higher education in surgery. He claimed (almost boasted!) that he had acquired proficiency in carrying out operations for hare lip, cleft palate, skin grafting, thrasher injuries and abdominal operations. In that stinking and dangerously unclean operation theatre and with inadequate and poor quality of surgical instruments? And how does he do all that single handed? Well, a ward boy had been 'trained' as an anaesthetist and the pharmacist served as the surgical assistant!

Another PHC, situated 75 Kms from Lucknow on the road to Hardoi, provides an instance of another type. Only one or two of the four physicians posted there commute from Lucknow in turns, arriving four or five hours late. They leave the PHC ahead of the schedule. The rest of the staff take the cue from the physicians and become nonchallent in their

work, including observation of the PHC timings. The people have long abandoned any expectations from the PHC and they depend on the private sector. They expect no change 'because the doctors have powerful political support'! The situation has swung to another extreme in more than one Subsidiary Health Centre (SHC) in Murshidabad district. Here the SHC has been attacked by bandits, who have looted the government property, not sparing even doors and windows! Fearing danger to life and limb of its staff, the state government authorities decided to abandon the entire SHC and withdrew its staff. These are now called 'Ghost SHCs'. That the people atleast acquiesced with such a literal daylight robbery speaks eloquently about the quality of 'community involvement'! Why, considering the uselessness of the SHC, it should not be very surprising the 'community' itself produced its 'bandits' to chase away the useless bunch of government functionaries! (Banerji 1989b; Banerji 1982)

Maternity Services: The PHC staff meet only a small fraction of the felt needs for maternity services. Quite often they had to be paid even for that. When the need is urgent people make special efforts to seek out the ANM or the Lady Health Visitor (Female Health Assistant) or the Lady Doctor at the PHC. Wherever the PHC has indoor maternity beds, there is great demand for admission. Often they have to have extra beds–on the floor. The mothers agree to come for antenatal visits in order to get admitted. This is despite very bad conditions in the maternity wards – very poor hygiene, broken beds, soiled mattresses and linin and very poor and callous service. Again, the 'cultural gap' is very wide indeed.

Pregnant mothers often take active steps to get tetanus toxoid protection. They also use iron and folic acid when supplied by the staff.

Implementation of National Health Programmes

Reference has already been made to the fate of tuberculosis patients in rural areas. The degree of implementation of the

National Tuberculosis Programme (NTP) provides a very valuable index of the degree to which rural health services meet people's felt needs for health services. NTP was specifically designed to develop with the development of the rural health services. Under the NTP, the PHC and other health institutions are provided facilities to investigate those who visit them with symptoms of tuberculosis i.e. they have felt need for the services. Less then a fifth of such symptomatic patients are investigated. Among this very limited number, in very few cases the sputum is examined for the bacillus. Most of them are asked to visit the nearest facility for X-ray examination. That means the poor patients have to travel out of the village and many have to stay overnight. Often they have to pay bribes for the services which are supposed to be free of charge. They have to come again to the town for getting the report. Then, if he is unfortunate enough to be diagnosed as a case of tuberculosis, he has to get the supply of drugs, which are often out of stock at the PHC.

However, there is enthusiastic participation in 'eye camps' organized under the National Programme for Control of Blindness or by other voluntary organizations. In fact, people throng in large numbers in specilized eye hospitals in cities and towns to seek help. Once again, they put up with a great deal of difficulties in gaining access to the services.

People 'cooperate' with functionaries of the Modified Plan of Operation for Malaria Control, as they have been doing during the days of the National Malaria Eradication Programme. Fever cases give blood smears to male MPWs and to Drug Distribution Centres and they take the presumptive treatment and, where needed, the redical treatment. However, the acceptance is passive. They have little idea of the purpose and basis of the programme.

An interesting manifestation of the potential of the people has come out of the field experience of the DANIDA Assisted Leprosy Eradication Programme (DANLEP 1988). The techno-managers, who seem to have acquired a vested interest in leprosy in India, have been following the old rule of thumb

technocentric approach to the problem of leprosy in India. The only social dimension was a monstrous distortion of the concept of stigma against leprosy. The significance of the DANLEP experience lies in the fact that here an effort was made to remove the element of fear from the minds of leprosy workers, the patients and the community at large (DANLEP 1988; District Leprosy Eradication Society 1989). The results in some villages in the Rajanandgaon district of Madhya Pradesh were most thrilling. DANLEP has demomstrated that once the fear element is removed, it is possible to mobilize entire villages to have a virtual festival to accept and take care of leprosy patients within the village itself, as well as from surrounding areas. It has been a remarkable experience to have the entire community, cutting across class and caste barriers, sitting together with leprosy patients to share a common meal which is contributed by villagers themselves. It is not a question of extensiveness of the phenomena; what it shows is the enormous potential that lies untapped among the people to cope with their own community health problems. The author and Thaneswar Bir (1990) had a similar experience of observing bustee dwellers of Daspara in Calcutta, on their own initiative, take action to bring about a dramatic improvement in their condition of living, including health behaviour. There are also reports of enthusiastic participation of Punjab villagers in 'Medical Manthans' (Government of Punjab 1987a) and Health Camps (Government of Punjab 1987b). There are great possibilities of exploring such potential for other community health issues, such as Tuberculosis, Malaria and Kala-azar. This might open up an entirely new area of democratization of health services in the country.

EFFORTS TO GENERATE FELT NEEDS FOR CERTAIN PROGRAMMES

Interestingly, while the decision makers have not been able to meet so much of the felt needs of the people, which also happen to be epidemiologically assessed needs, they have made strenuous efforts to actively generate felt needs or

'motivation' for programmes which they consider to be important for the people — particularly family planning and immunization and other UNICEF initiated programmes for 'child survival'. Indeed, in the earlier period, they had invoked some obviously biased social science studies (WHO 1983a; Banerji 1986b: 47-51) to emphasise the need for health education of people: health education was to be *given* to the people. It used to be paternalistic and patronizing (WHO 1983a). While not so brazen in its approach, the same principle is being followed in whipping up enthusiasm for the family planning and child survival programmes. This is the programme for 'Information Education and Communication' (Bergstorm 1980; Bose 1988). Marketing experts have now come forward with another term, 'social marketing' (Manhoff 1984), apparently to distinguish it from the much more obvious motivational manipulation techniques of commercial marketing. However, the coining of the term itself is an effort to hide the real intention: who is to decide whether the 'product' to be marketed is 'social' or commercial? Are the *people* involved? What is the link between social marketing and market interests who want to create dependence? How consistent are the marketing of technocentric, target-oriented, time-bound programmes with the commitments to democratisation of health services made in the National Health Policy? Apart from some fundamental social, cultural and political issues, this also raises important ethical issues: issues of motivational manipulation ethics of generating felt needs for other problems when the organization has so conspicuously failed to meet the pre-existing felt needs and ethics of making patently unfounded claims in favour of some products (Banerji 1986b), are examples.

Fortunately for the people, because of some basic weaknesses at levels of policy, strategy and programme formulation, action and evaluation, the impact of IEC has been very muted, even though considerable amount of money has been spent on it (Bose 1988; Bergstrom 1982).

THE FAMILY PLANNING PROGRAMME

It is a paradoxical situation. While there is considerable unmet need for family planning services among a substantial section of the people and many of them have willingly undergone sterilization or adopted other means of family size limitation, including induced abortion, there is a strong disdain and antipathy for the Family Planning/Welfare Programme and the health and revenue and other types of functionaries associated with it. These people are perceived as scheming persons, who are out to 'catch' them for sterilization, by any means, fair or foul. People have become 'targets' of their own government. The government propaganda machinary claims that population growth is eating away the fruits of development and that a small family will be a happy family. But people ask: who has been eating the fruits of development during the past four decades? What type of health services are available when their children fall sick? What will happen to them in old age? What about employment? about social justice? about literacy, particularly about female literacy and status of women? and so forth. Family planning workers do not and can not answer such questions; all they want are the 'cases' to meet the targets set for them from above. Such unethical means lead to undesirable ends. A section people see the programme as a menace.

Family planning workers also do not like the work at all. They do so because they are forced to do so, under threat of serious administrative sanctions. Family planning performance is entered in the character rolls of collectors and other senior bureaucrats.

UNIVERSAL IMMUNIZATION AND OTHER PROGRAMMES FOR CHILD HEALTH

As if the damage to the health services by the family planning programme was not serious enough, under strong encouragement from UNICEF and WHO, UIP was launched in 1986 to vaccinate all the children born against six diseases

by 1990 (GOI 1985a). It is technocentric; it is imposed by the Union Government on the people through the state governments; it is target-oriented; and it is time bound. All the defects that one can think of in a programme! It is massive in size, involving high costs, with a strong dose of IEC and social marketing.

Apart from UIP, UNICEF also advocated growth monitoring, oral rehydration and breast feedings (GOBI). Growth monitoring of children was not done. In any case, as pointed out by Gopalan (1987), it is a futile excercise in the absence of facilities for follow up action. The failure in the implementation of the oral rehydration was dramatically demonstrated when it was discovered that at the time of the epidemic of gastro-enteritis in the nation's capital, very few even knew about it (Banerji 1989a; VHAI 1988). Advocacy of breast feeding is like preaching the converted. The problem is gross inadequacy of breast milk to feed the infants — in West Bengal only 51 percent did exclusive breast feeding upto two months; it fell to 35 at the end of four months and to 20 at six months. The correpsonding figures for Maharashtra were 85, 66 and and 35 (Gopujkar et al 1984). Senapati (1987) also reported similar situation in his study population.

In an extensive, multicentric evaluation of the massive Integrated Child Development Services, conducted by the Nutrition Foundation of India (1988), a number of serious shortcomings have been pointed out. Most ominous of them is that ICDS has degenerated into a concern of the 'provider and the bureaucrat'. It is doomed, Gopalan (1988) has warned, "unless the community takes the 'front seat' in the implementation of the programmes".

VILLAGERS' ACCESS TO MORE SOPHISTICATED HOSPITALS

One positive feature of the government health services is that almost no charge is levied for its services. There has been

such a loud public outcry against a proposal to levy of even small fee for the services that the government was forced to beat a hasty retreat (Editorial Comment 1980). If a perceptive PHC physician suspects a brain tumour in a poor villager, he at least has a chance, however small, of gaining access to the most sophisticated postgraduate teaching hospital in the city, free of charge.

However, in reality, the referral system from PHC is virtually non-existent, except for some rudimentary organization in the case of programmes for tuberculosis, eye diseases and leprosy. People are left to fend for themselves to find access to more sophisticated hospitals. Sheila Zurbrigg (1984) has given a graphic description of what it meant for a poverty stricken mother to seek assistance from the nearest hospital for treatment of acute diarrhoea of her infant. The ordeal increases several-fold when the diseases are more serious and complex, involving more elaborate treatment in hospitals located farther away – travel of long distances with the patient, arrangements for stay in the unfamilier and impersonal urban conditions, the hassels to get admission, and, for those who are lucky enough to get their patients admitted, the trials and tribulations of the relatives to provide support to the patients and to obey the doctors' orders to purchase medicines from the market. Then, there is the yawning 'cultural gap' between the patient and the hospital staff – he is a poor villager in a Western style hospital, with its own procedure for cure, peculiarities of human relation with the hospital staff, diet, bedding, toilet facilities and visiting hours. Besides, the patients and their relatives have to suffer consequences of the not so infrequent serious mistakes and criminal professional negligence of the hospital staff. There are numerious horror stories in newspapers about the 'hellish' conditions in hospitals. One of the most dramatic of them was the shameful tragedy of deaths of infants in the venerable Medical College, Calcutta, because of pressure due to closure of a ward in another teaching hospital in Calcutta because of outbreak of tetanus

(Mukhopadhayay 1989). The Lentin Commission (Government of Maharashtra 1986) has discribed the criminal nexus between unscrupulous medicine suppliers, politicians and hospital staff in another hoary institution in the country – JJ Hospital in Bombay. If this is the situation prevailing in the top most hospitals in the country, it is not difficult to imagine the plight of the helpless patients in other government general hospitals and district and sub-divisional hospitals. Patients are helpless because that is all they can afford. The political pressure is not yet strong enough to ensure that those responsible for providing health services – from the political leader down to the health guide – are held accountable for their actions. This, as would be pointed out later on, is a part of the serious crisis in the medical profession in the country.

CHAPTER SEVEN

DECISION MAKING IN HEALTH SERVICES

The glaring shortcomings noted in the 'people's eye view' of the health services presented earlier are in fact mer symptoms of the deep-seated malady that afflicts the health and family planning services of the country. As pointed out in the earlier parts of this presentation, profound socio-cultural and political issues lie at the root of this malady. Here, only a very brief mention will be made as to how these factors have affected the administration of the health services of the country.

QUALITY OF PUBLIC HEALTH PRACTICE IN INDIA

The National Health Policy had envisaged fundamental changes in the public health practice to 'bridge the cultural gap between the people and the personnel providing health care' to develop and put into operation endogenously developed alternatives to Western models of manpower development and medical care services, to provide health services coverage to the unserved and the underserved, to place the health services in an intersectoral context, to improve the health status of the people, to ensure organised involvement and participation of the people in the planning, formulation, implementation wand evaluation of the health services that are meant for them.

Perhaps by far the most unfortunate aspect of health service development in India since the declaration of the

policy is that, instead of rising to the challenge of implementing it, there has been a steep decline in the quality of public health practice. There has been a precipitous decline in the quality of public health practioners (Banerji 1988). As a result, some of the key public health posts in the health administration at the union and state levels are filled by clinicians and teachers from pre-clinical and paraclinical disciplines — anatomists, pharmacologists, pathologists, biochemists and physiologists. The generalist administrators have also taken advantage of this weakness among public health practioners by taking over positions for themselves which in fact required high degree of epidemiological and other technological competence. The technical post of commissioner, family welfare, at the Union Ministry of Health and Family Welfare was taken over by them in the mid-seventies. Later, at some places, they had even taken over implementation of the family planning programme at the state level. The Divisional Commissioners and the District Collectors became main leaders for implementing the programme, with Directors of Health Services, and the District Chief Medical Officers playing a subsidiary role. The Director of the Technology Mission on Immunization, which required such a high level of competence in epidemiology, medical technology and public health practice, is a joint secretary in the Union Ministry of Health and Family Welfare! The generalist administrators obviously do not have either the qualifications or the competence to run such complex and massive public health programmes. Worse still, unlike health professionals, they cannot be held accountable for their decisions, because they are frequently transferred to altogether different areas of responsibility: a classical instance of authority without responsibility.

The composition of the Task Force on Immunization constituted by the Government of India (1985a), which formulated the ill-conceived (Gupta and Murali 1989) Universal Immunization Programme (UIP), provides a very striking example of the quality of public health practice at the

highest level of the government. It was headed by the then additional secretary-cum-commissioner of family welfare of Union Ministry of Health and Family Welfare. He had come to that post on promotion from the Ministry of Finance, and later on, he was transferred from family welfare to a position which dealt with rural development. Significantly, the two medical personnel who were singled out for their contribution to the deliberations of the Task Force did not have any public health training or experience: one specialised in pathology, while the other was an anatomist.

The political leaders heading the governments at cabinet and health ministry levels at the centre and the states must be squarely held responsibie for this sad state of affairs. They had remained inactive when there was a steep fall in the quality of public health practice in India following their decision to abolish the all-India cadre of the Indian Medical Service of the colonial days. They had approved appointment of obviously unqualified medical personnel to key public health posts. They also allowed the generalist officers to exercise authority in technical fields and for not holding them accountable for their decisions.

BREAKDOWN OF THE PUBLIC HEALTH SYSTEM

This neglect of some of the basic principles of public health practice has had very serious consequences for the country. Because of domination of the family welfare programme by generalist administrators, it degenerated to a game of numbers — attainment of 'targets' for contraceptive use among the 'eligible' couples. Giving the overriding priority to achieving targets sometimes by using unfair means led to neglect of other health services, even the services concerning mothers and children. It is now being increasingly realised (GOI 1987b) that, despite the massive efforts by generalist adminstrators, the reduction in the rate of population growth has substantially fallen short of the expectation.

There were equally glaring shortcomings in the brueaucratic approach adopted in the formulation of the Universal Immunization Programme launched at the behest of the Task Force (GOI 1985a). Such a massive programme involving an additional investment of 2.5 billion rupees was launched without even defining adequately what the problem was: the size, distribution and time trends of the six diseases chosen for immunization. Similarly, the programme was sought to be implemented through the existing health service system without ascertaining the capacity of the system to sustain the cold chain which is so vital for the potency of the vaccines, and to be able to undertake the massive task of getting the immunization coverage, over and above sustaining its work in the fields family planning and other activities included under primary health care (Banerji 1988).

It is not being suggested that immunization of children against communicable diseases is in itself an undesirable act. However, in this case, an obviously poorly designed, technocentric and dependence producing programme is seen as an obstacle to the implementation of primary health care as enshrined in the Government of India's own National Health Policy. In the context of primary health care, immunization programmes are considered as integral components of a health service system based on community self-reliance and respect for the people's democratic rights by involving them in every phase of the development process. Finally, the possibility remains that even in the unlikely event of it becoming possible to implement the immunization programme in such a way as to give satisfactory coverage and make an epidemiological impact, that the children who might have benefited from the programme would fall prey to other diseases caused by the unhealthy environment in which they are forced to live. Therefore, even with the most optimistic scenario, it can be claimed that the operations were successful but that most of the patients died. WHO, along the UNICEF, some other international agencies and affluent countries, have been at the forefront in 'selling' the immunization

programme on a global scale. However, weaknesses of UIP are now becoming increasingly supparent (Gupta and Murali 1989; Banerji 1989b). Among the latest to admit them has been the Director-General of WHO (WHO 1988; Nakajima 1989).

More recently data have been made available from broadbased, systematic surveys organized by an Independent National Review Committee on UIP under the sponsorship of the National Institute of Health and Family Welfare (Gupta and Murali 1989). The surveys included 25 districts from twelve major states (and Goa). The data confirmed the worst of the forebodings of several scholars made way back in 1984, 1985 and 1986 (Banerji 1984c; Grodos-et-de Bethune 1985; Banerji 1986a). In states accounting for more than half of the population of the country, less than fifth to a third of the eligible children were fully protected against the five deseases: the coverage hit almost the rock bottom when measles was also included as the sixth desease (Gupta and Murali 1989). Even in the best performing states, which accounted for a tiny fraction of the total population, the coverage did not reach the prescribed 85 per cent — it wavered between 70 — 83 per cent. Again, these very states (e.g. Kerala, Himachal Pradesh and Goa) already had low mortality and morbidity rates and therefore the impact of the coverage will naturally be very limited. The coverage was abysmally low in the very states which are expected to have high incidences. These high desease incidence states, again, have very low figures for female literacy, per capita income, allocation for health services and in their levels of management (see Table IV, p. 107). The Technology Mission had made a serious blunder in overlooking the glaring differences in the organisation and management of the state health services and imposing a 'central pattern' on all of them.

Gupta and Murali (1989) have also noted very serious shotcomings in the actual process of implementation of UIP — operational managerial proceses, training, information,

education and communistation, disease surviellance and coordination.

MANIPULATION OF INFORMATION

One of the most ominous consequences of this increasing breakdown of the public health services in the country is the tendency among the concerned administrative and political authorities to attempt to cover up their shotcomings. The most frequently used tactic is not to collect any data at all, thus protecting themselves against any criticism. There are also active efforts to suppress whatever information that is available with the authorities. Finally, they have used the fast developing techniques of disinformation under the garb of social marketing and Information, Education and Communication (IEC). The massive unsubstantiated propaganda barrage by UNICEF and WHO, claiming successes of the Expanded Programme Immunization (Mahler 1987) and the Child Survival Revolution (Grant 1985), provide a very disturbing example of dissemination of disinformation. At home, there is the example of family planning authorities making questionable claims concerning 'couple protection' and 'number of births averted' on questionable assumptions and based on data which often have a high degree of unreliability (Bose 1988; Bose 1989).

As will be pointed out below, this tendency to aviod collecting information or supressing or distorting them and unleashing a massive barrage of disinformation and cheap propaganda gimmicks poses a serious danger to the health of hundreds of thousands of citizens of the country.

'EPIDEMIC' OF EPIDEMICS OF INFECTIOUS DISEASES

The consequences of such neglect of public health practice by the political leadership of the country have been devatating. Epidemics which had become unknown, have started to stage a come-back. What is even worse, the persons responsible for protecting the health of the people seem to

have forgotten the time tested (colonial!) methods of prompt identification of an epidemic and immediate initiation of steps to control them. Before the fifties, Kala-azar was a major public health problem in the eastern and north-eastern regions of India, causing considerable suffering and death. However, even though no specific public health measures were taken, in the next two decades or so, the incidence of the disease came down dramatically and Kala-azar ceased to be a public health problem. That senior medical scientists in the numerous national institutions did not even have the curiosity to find out the reasons behind this decline is one more striking example of their lack of sensitivity to important events in the field of public health.

During the past several years there have been frequent newspaper reports of outbreaks of Kala-azar in many of the eastern states. Little more than ritual action had been taken to study the epidemiology of the disease and to draw up an effective strategy to deal with it (VHAI 1989; ICMR 1982; ICMR 1989b). Similar neglect has been observed in responding to repeated outbreaks of Japanese encephalities (ICMR 1980; Das 1989) in different parts of the country for a number of years. The response was similar to the frequent outbreaks of 'viral fevers', viral conjunctivities, infective hepatitis, bacillary dysentery and cholera and gastro-enteritis in different parts of the country (Banerji 1989a; Editorial 1990).

The Bhopal Tragedy, which is regarded as the worst industrial disaster in the world, occurred because the insecticide plant was situated so close to a thickly populated area, the owners of that plant were so callous and criminally negligent that they failed to take the many safety measures which have been mandated to them and they did not even care to inform the exposed population of the measures they could take to protect themselves in the event of an accident. The Government of India mobilised the Indian Council of Medical Research to make a study of the disaster. The ICMR built-up a huge multicrore research empire, but they could

not collect some of the most elementary epidemiological data on the disaster (Banerji 1984a).

THE CHOLERA EPIDEMIC OF DELHI:

A CASE STUDY OF PUBLIC HEALTH ACTION

The recent visit of cholera to the national capital is symbolic in more than one sense. It came when the nation was 'celebrating' the fortieth anniversary of independence and the tenth anniversary of the Alma Ata Declaration. It is a part of the symptom complex arising out of the utter failure of the concerned authorities to provide to vast masses of the people of this country the minimal quality of living conditions necessary for living a healthful life and of providing protection to people against the onslaught of epidemics of many diseases (VHAI 1988).

Those incharge of protecting the health of the citizens of Delhi seemed to have lost even the faculty of recognising a serious outbreak of gastro-enteritis. Predictably, although the city is generously endowed with a variety of health workers to guard the health of the citizens, nobody seemed to be there when the cases started to occur more frequently (VHAI 1988). On their own, the victims had to rush to public hospitals and the various private practitioners. Even when the public hospitals reported the cases, it was dismissed by the authorities as a 'seasonal event'. Even when, after an unpardonably long interval, the National Institute of Communicable Diseases diagnosed some of these cases as those of cholera and similar diagnosis was also confirmed in some other hospitals, no efforts were made to rush back to the affected areas and make the necessary investigations and take the needed preventive measures. The people were left to fend for themselves. It was only when the epidemic became even more intensive and, following newspaper reports, the Prime Minister of the country rushed to the scene that the authorities were forced to swing into action. Only then the state controlled radio and television reported that there had

been an epidemic in Delhi. Again, the actions did not conform to the scientific requirements for containing and then eliminating an epidemic (VHAI 1988). The steps taken were of *ad hoc* nature, more as a public relations excercise.

The administrative head of the Municipal Corporation, again a generalist administrator, developed his own definition of what could be called an epidemic and he solemnly declared that it was not an epidemic (VHAI 1988).

It is significant that, out of the 8,788 cases of gastro-enteritis admitted to various hospitals, there were as many as 305 deaths. It is now well recognized that it is possible to provide very effecacious treatment from even very modest hospitals and that this should bring down the mortality virtuality to nothing. That this was not the case provides on idea of the quality of the services provided by some of the top hospitals of the country (VHAI 1988). It also did not come as a surprise that very little effort was made by the hospital authorities to join hands with the public health officers to help in locating the foci of the epidemic, so that the urgently required preventive measures could be taken.

As pointed out in Chapter Seven it was also found that even the people of the nation's capital had little knowledge concerning Oral Rehydration Therapy, so enthusiastically promoted by UNICEF.

CHAPTER EIGHT

HEALTH CARE DELIVERY SYSTEM

UNION LEVEL LEADERSHIP OF THE HEALTH ADMINISTRATION

Even though health is regarded mainly as a state subject, because of certain compelling situations and reasons (some of them have been referred to earlier), the Union Ministry of Health and Family Welfare had come to play by far the most dominant role in the development of the health services in the country. This implied that the persons involved in providing leadership at the union level had the competence to face the new challanges thrown up by the policies and programmes adopted in the country after independence.

It may be recalled that in the colonial days the dominant role was played by the Director General of Health Services (DGHS), who also headed the all-India cadre of Indian Medical Service. He was, in a military sense, at the apex of the command of the health services of the country, being responsible for curative, preventive, education and training and research institutions at the federal level. The Health Secretary, who belonged to the ICS cadre, had a marginal role, dealing with general administrative problems which go beyond the scope of the technical considerations in the health services. As pointed out above, after independence the responsibility of the DGHS has expanded manyfold,

corresponding with the manyfold developments within the health services in independent India.

To meet the formidable challenge after independence, the DGHS was required to mobilise research resources to optimise health service systems at various levels. He was required to provide leadership in initiating interdisciplinary operational research studies for formulating national programmes and in forming a network of health services within the country. To meet the requirements of such health services, he had also to take initiatives in promoting development of suitable manpower, which includes physicians, nurses, para-medical workers, etc. By far the greatest weakness in the health services system in independent India is that, instead of getting strengthened, the roles and responsiblities of the DGHS have been seriously compromsed and eroded (Banerji 1985a 47-49). He has been left heading the trncated and mutilated cadre of the Central Health Service, which is dominated by clinical specialists and superspecialists belonging to large general hospitals and teachers of medical colleges.

As mentioned earlier, one of the most distressing outcomes of the leadership of health administration at the union level has been a sharp increase in the influence in the administrators belonging to the generalist cadre of the IAS. Logically, developments after independence should have led to the virtual withering away of the generalist wing in the Ministry of Health and Family Welfare. That task should have been taken over by the new breed of *Managerial Physicians* who would have developed, over time, competence and experience in both managerial and technological fields. Instead, obviously because of the failure of the health administrators at the union level to rise to the occasion, a serious situation has been created where it is the generalist administrators who are taking decisions on some of the most vital components of the health services of the country. It started with the formation of a separate Department of

Family Planning outside the purview of DGHS. Subsequently, the vital area of maternal and child health was taken away from the purview of the DGHS. When the Community Health Volunteer Scheme was launched, it was done by the Department of Family Planning. Presumably taking advantage of the moribund state of the Directorate General of Health Services, the Department of Family Planning has now taken upon itself almost the entire responsibility of the rural health services in the country. Again, it is the Department of Family Planning which is responsible for the formulation of the Universal Programme of Immunization (UIP). The Department of Family Planning also took upon itself the responsibility of launching the Area Projects (Banerji 1985a: 318) which cost Rs. 2.5 billion and which covered 65 districts of the country.

As is evident from analysis done thus far, the lapses in the performance at the union level have had far reaching effect on the planning, formulation, implementation and evaluation of health services in the country.

STATE LEVEL LEADERSHIP OF HEALTH ADMINISTRATION

The state level leadership is also of crucial significance because it is the state governments which are responsible for the actual implementation of the various health policies and programmes. Because of the rising aspirations of the people and the corresponding expansion of the health services, both in quantity as well as quality, the demand on the health administrators at the state level had also correspondingly increased. Unfortunately, once again the health administrators have failed to live upto that responsibility. This has had major repercussions on the entire health service system in the states. In the first place, a state director of health services (DHS) is also required to play a pivotal role of providing leadership to the entire health service system, including implementation of the various programmes, education and training of various types of health workers and

of providing research support to the different programmes. One feature, which can be considered as common with all the states of the country, is that there has been a very significant decline in the competence of directors of health services. Correspondingly, as has been the case at the union level, there has been a very rapid expansion of the range of activities of generalist administrators in areas which require very high level of technological and epidemiological inputs. The consequences of such an imbalance have been far reaching. These account for the many setbacks in many of the key health and family planning programmes in the country.

Strengthening of the leadership in health administration at the state level is therefore as crucial as that at the union level. As the health administrators working at these two levels are the pace setters, they are by far the most important factors in the growth and development of the health services in the country. Because of these considerations, these issues have received the most important place in the framing of the recommendations made in this presentation (Chapter Fifteen).

HEALTH CARE DELIVERY IN RURAL AREAS

Sharp deterioration in the quality of public health practice, along with a precipitous decline in the quality of administrative leaderships at the union and state levels have their repercussions on the extent and quality of preventive, promotive, curative and family planning services in rural and urban areas. An extensive account of what the people themselves think of the delivery system has been given in Chapter Six. In the case of the nineteen village study, this has been repeatedly cross-checked during 1972-1988 in the eleven primary health centres and two subcentres which had been included in that study. The picture is similarly dismal in the numerous field studies conducted by the faculty and students at the Centre of Social Medicine and Community Health of Jawaharlal Nehru University (see, for instance,

Qadeer 1985; Sahu 1980; Raye 1982; Rao 1982; Senapati 1987; Buddakoti 1988). An extensive, statewide study, conducted by a Committee on Health and Family, Welfare (1988) of the West Bengal Legislative Assembly (1988), also reveals a very sorry state of affairs in the health care dilivery system in rural and urban populations. A similar picture emerges from an all-India study of 196 PHCs, mostly situated near district headquarters, conducted by the Indian Council of Medical Research (1989a). As pointed out earlier, the Familiy Planning Foundation (1987) had also organized a multicentric study to provide insights into the health care delivery systems in three hill districts and five plains districts of Uttar Pradesh, five tribal districts of Orissa and ten tribal and non-tribal districts of Madhya Pradesh, five districts of Karnataka. Similar extensive studies have been carried out by the Operations Research Group (1987) Baroda; baseline studies have been conducted in connection with the Area Projects, which covered 65 districts in the country (Banerji; 1985:205, 207); an elaborate nationwide study has also been conducted to study the health care delivery system in the course course of an evaluation of the National Tuberculosis Programme. (ICORCI 1988). More details of the literature studied for this purpose are given under Annexure 'A'. With such a massive data base, it is possible to come to some general conclusions concerning the health care delivery stystems which are applicable to atmost all shades of the rural population of the country. These are, very briefly, presented below.

The district health organization forms a critical point in the network of the health services in the country. Apart from providing direct, services to the population through the district hospital, it is required to play the vital role of providing support to the various peripheral health agencies within a district. The competence of the chief medical officer and his team of district level officials is central to the success of the work in community health centres, primary health

centres, sub-centres and taluk hosptials and dispensaries. From the data collected from the various studies referred to above, it is apparent that the erosion of the quality of public health practice has a particularly devastating effect at the district level. There is very little of supportive supervision to the health agencies in the district. Personnel working in these agencies also do not receive adequate support in the form of supplies of drugs and equipment and general administrative and financial back up. The health information system is very defective, both in terms of coverage as well as in quality. Political interference in the day to day functioning of the health services is frequent. In its turn, the district health administration does not get the needed support from the state level health officials. Perhaps the worst feature in the health care system as a whole is the relentless pressure from the Union Government for attaining certain specified targets concerning the 'centrally sponsored' programmes. As pointed out earlier, such a mechanistic, authoritarian approach to programmes, which are formulated without even involving the state governments, has created such a backlash that the states have ceased to have any stake in them — they are considered as 'Centre's Programmes'!

At the level of health workers in villages, sub-centres, primary health centres, community health centres, taluk hospitals and dispensaries, the picture is equally dismal. There are shortfalls in almost every facet of performance of the health services. These are the cumulative results of the inability of the administrators at the district, state and union levels to offer the right kind of leadership to the health services of the country.

Making a mere quantitative addition ('more of the same') to a programme which is poorly conceived and even more poorly implemented actually amounts to expansion of ineffeciency. The consequences of the expansion of the infrastructure are even more disturbing. Who is to supervise the functioning of the numerous subcentres? The lone

physician at the New PHC simply can not do that for the six subcentres in his area; nor can it be done for the twenty subcentres by the medical officer of the Community Health Centre.

As at the district level, particularly unfortunate is the devastation wrought by the family planning programme. Coercive methods have been used extensively to ensure attainment of the family planning targets set by the Union Government. Enormous pressure is put on health workers to ensure that they attain the prescribed targets. It not only has a profound demoralising effect on all the health workers in rural areas, but once a health worker manages to attain the targets given to her, she feels that she does not have to worry about the other items of the work that she is required to perform. So intense is the pressure for attainment of the targets that administrators even at the highest level seem to forget about the necessity of performance of the other duties by the health staff. This has had very disrupting impact on the work in the rural areas. Launching of yet another target oriented programme in the form of the Universal Immunization Programme has now confronted the peramedical workers with yet another set of targets.

REGIONAL VARIATION IN HEALTH SERVICE DEVELOPMENT

Several references have been made earlier to the fact that as much as 80 to 90 per cent of the health institutions in India are working at an unacceptably low level of efficiency. However, here it is intended to underline very sharp regional variation even among these less than efficient health institutions. Six States–Uttar Pradesh, Bihar, Rajasthan, Maharashtra, Tamil Nadu and Kerala — have been chosen to give a perspective of variations among them in terms of a number of demographic, social, economic and health service variables. These are summed up in Table-IV.

Another interesting source of information concerning

Table IV *Comparson of Six States in Terms of Different Variables*

	U.P.	Bihar	Rajasthan	Maharashtra	Tamil Nadu	Kerala
1. Birth Rate (1986)	38.0	38.1	38.6	30.0	25.5	22.6
2. Death Rate (1986)	16.1	14.4	13.1	8.7	9.9	6.3
3. Infant Mortality Rate (1987)	126.0	102.0	103.0	66.0	76.0	26.0
4. General Fertility Rate (1985)	172.7	169.2	180.1	117.4	94.1	83.9
5. Gross Reproduction Rate (1985)	2.6	2.5	2.6	1.7	1.4	1.2
6. Percent Couple Protected (1988)	28.8	22.9	27.8	54.4	52.5	46.3
7. Decinnial Growth (1981)	+25.49	+24.06	+32.9	+24.54	+17.50	+19.24
8. Total Population 1981 (in lakhs)	1108.6	699.1	342.6	627.8	484.1	254.5
9. Rural/Urban Distribution (1981)	U17.95	12.47	21.05	35.03	32.95	18.74
10. No. Female per 1000 (1981)	885	946	919	937	977	1032

(Contd.)

		U.P.	Bihar	Rajasthan	Maharashtra	Tamil Nadu	Kerala
11. Literacy (1981)	M	38.76	38.11	36.30	58.79	58.26	75.26
	F	14.04	13.62	11.42	34.79	34.99	65.76
12. Per capita Health Expenditure (1986)		26.51	23.79	65.87	63.43	47.57	45.36
13. Bed/Population Ratio (1988)		2577 (1.1.86)	2876	2039	775	1182	391
14. No. Doctors Admitted for one lakh Population (1981)		0.96	0.76	1.35	2.34	1.17	2.31
15. Medical College/Population Ratio (1981)		1:123	1:77	1:68	1:48	1:53	1:63
16. Per capita NDP (1987)		2146	1802	2150	3793	2732	2371

Source: Compiled from tables in *Health Statitics of India* 1981, 1982 *Health Incormation India* 1988 and *Family Planning Year Book:* 1981-82, 1983-84 and 1987-88.

regional variation is the series of Occasional Papers of 1988 and 1989, brought out by the Demography Division of the Office of the Registrar General of India (GOI 1988). In these documents, a very ingenious effort has been made to rank order all the 439 districts of the country in terms of death rates by age two, calculated from the data of the 1981-Census. Excluding the metropolitan cities, the first ten districts in the rank order are: Manipur Central (Manipur); Kottayam (Kerala); Ernakulam (Kerala); Alleppy (Kerala); Wokha (Nagaland); Mnipur South (Manipur); Trichur (Kerala); Trivandrum (Kerala); Quilon (Kerala; and Mahe (Pondicherry).

It may be noted that while Kerala accounts for six of the ten districts, its Wayanad District occupies the rank of 77, Idukki, 50, Palghat, 36, and Malapuram, 26. The mortality rate (by the age of two) of Wayanad is 89, as compared to that of 37 for Kottayam. Besides, a report from the Kerala Shastra Sahitya Parisad (1989) paints a gloomy picture of the public health and medical care services scenario in Kerala. Kerala also happens to be among the lower most states in terms of access to protected water supply and sanitary latrines, according to the 1981 Census (GOI 1989b). It has also been repeatedly observed that the percentage of the people living below the poverty line is also significantly below the national average (National Nutrition Monitoring Bureau 1989).

It may, however, be pointed out that taking states as units of comparision may not present the entire picture. For instance, among the ten districts of the country which have the highest mortality rates (GOI 1988), six are from Madhya Pradesh and two each are from Uttar Pradesh and Arunachal Pradesh.

HEALTH CARE DELIVERY SYSTEM IN URBAN AREAS

The situation in urban areas is much more complex and different. Reference has already been made in Chapter Six to the major advantages enjoyed by those who live in urban

areas. The National Health Policy has referred to disproportionately large investment made in urban areas in the form of sophisticated hospitals and medical care facilities. The investment made for such preventive services as water supply, sewerage, environmental santitation, city planning, housing, etc. is also proportionately more. In terms of means of transport, mass transit, access to media of mass communication, literacy level, employment, education and electrification, the urban populations rank much higher than their rural counterpart. Because of these many advantages, basic health indices, as measured in the terms of crude death rates and infant mortality rates, are much more favourable.

Historically too, the rulers had made conscious efforts to build for themselves 'healthy localities'. During the colonial days, these were in the form of cantonments and civil lines (Jeffery 1988). This tradition has been continued by the new rulers who took over power after independence. This has also given a polorised structure to urban settlements in India. This polorization is much sharper than in the rural areas. The rich and the powerful in urban areas have been much more successful in building enclaves of healthy localities for themselves, leaving the poor to their fate.

It is not necessary here to enter into the discussion concerning the rates of urbanization and the rapid expansion of the slum population in India's cities. However, because of the pressure from rural areas, there is now growing concern about the fate of Indian cities, particularly the metropolitan cities. There, people living in slums account for as much as a third to half of the total population. Another half of the remaining population is forced to live under conditions which can hardly be called 'healthy'.

The 1981 - Census has already revealed a major shift of population from rural areas. The number is certainly going to increase much more when the 1991 Census is undertaken.

Correspondigly, this will exentuate the health problems of the majority of the people living the urban areas. The recent outbreak of epidemics of meningitis, infective hepatitis, bacillary dysentery and cholera and gastro-enteritis are grave pointers to the deteriorating health conditions in urban area (Banerji 1990). Similar finding had been observed in a recent study of of Bombay slums by D'Souza (1987).

Thus, despite enjoying many more privileges than rural areas, despite much wider network of services available and accessible to the poorer sections of the society, the intensity of suffering of the masses due to health problems in urban areas is rapidly increasing. This is primarily due to the ecological conditions in which the poor people are forced to live.

Another important consideration is that enough efforts have not been made to find ways of reorientation and reorganisation of the existing health insitutions, in order to provide more effective services to the poorer sections. A Government of India's (1982) (Krishnan) Committee has made recommendations which call for still greater investment to set-up a network on the lines which have been developed in rural areas. That the members of this committee should show such a lack of imagination can be understood from the fact that all of them have been generalist administrators, who had little understanding of the wider sociological, edpidemiological and technological issues involved in building up health services for urban areas. These busy administrators held four meetings (and invited some technical personnel) to come to their conclusions. It is this almost casual, impressionistic method of decision making which is responsible for the many of the setbacks in health service development in India.

It may, however, be noted that some efforts were made to conduct some form of action research in urban areas, with a view to developing an alternative model. Particularly

noteworthy are the efforts made by Calcutta Metropolitan Development Authority (see, for instance, Rao 1981; CMDA 1983; Banerji 1988). Gopa Kothari (1989) has also made some tentative efforts to develop 'Alternative Models for Health and Family Welfare' for slums in Bombay. However, thus far, nothing of substance has emerged from such experiments.

CHAPTER NINE

THE FAMILY WELFARE PROGRAMME

As has been repeatedly pointed out earlier, the family planning/welfare programme has been the darkest and the biggest blot in the landscape of the health services in India. The Seventh Plan outlay for this programme is Rs. 34.50 billion; the outlay for all the health programmes combined for the Seventh Plan is Rs. 33.93 billion. Over the years, the family welfare programme has taken the shape of a gigantic organization with its ramifications reaching right upto every village of the country. Massive inputs have been made in the fields of mass communication and education, training, monitoring and evaluation and research to provide support to the programme. The Government of India (1987b) itself has now admitted that the efforts made thus far have not yielded the desired result. In a recent paper, Ashish Bose (1989) has made some very perceptive comments:

> .... It is paradoxical that in this scheme of things, there is no attention given to the Family as an institution, and to the role of family solidarity in fighting physical, social and economic insecurity. And yet life revolves round the family in India, perhaps much more than in any developed country of the world. Anybody coversant with the field situation will testify that for thousands of family welfare workers and millions of acceptors and potential acceptors of one or the other method of family limitation, the *family welfare* programme is perceived as the *family*

> *planning* programme, which in turn means the *female strilisation programme*, which basically means the *laparascopic method of sterilisation.*

Further on, Ashish Bose comments:

> As things are, it seems most unlikely that the birth rate of India will be 21 in the next 11 years or so. In the last seven years, the birth rate has declined by less than 2 points per thousand. A simple extrapolation will show that judging by past trends, the birth rate of India in 2000 will be around 29 and if the death rate is around 9, the population growth rate will be around 2 per cent per year, even at the end of the century.

The Government of India has been aiming at increasing the percentages of couple protection rate (CPR) over the past two decades. This is being used as an important measure of achievement of the programme. It is now becoming evident that quite often there is virtually no correlation between CPR and the birth rate (GOI 1987b). This is particularly disappointing, because throwing to the winds all the commitments it had made in its various policy documents (for example, GOI 1980), as pointed out by Ashish Bose (1989), the programme has degenerated virtually as a programme of catching people for sterilisation. For this purpose, the political leadership has not hesitated to handover the programme to the generalist administrators, starting from the Chief Secretary going down the Divisional Commissioners, the Deputy Commissioners, the Sub-Divisional Officers, the Tehasildars to the Patwaries. They have used various types of coercive tactics to catch people. Health workers are also subjected to intensive coercive pressure.

The growth of the family welfare programme in India provides an account of the extent to which the political, bureaucratic and professional leadership had gone to ensure

that the prescribed family planning targets are attained. It is this attitude which culminated in the programme of intensive family planning drive during the Emergency. An analysis of the activities of the past ten years reveals that, after the downfall of the Janata Party Government, the family planning programme has once again taken the shape of a full-fledged movement where all sorts of means are used to somehow catch people and sterilise them; only difference is that this time they have only stopped short of threshold which had precipitated with the massive political backlash of the Emergency days.

It is often contented that the increasing numbers 'are eating away the fruits of development'. It is conveniently overlooked that it is the small elite class which had cornered most of the fruits of development over the past forty-two years. Development programmes mean little to a vast majority of the population. What stake such people are expected to have for such an unjust social system? Such a social situation also makes it almost imperative that the minority, privileged class, which is controlling the economic resources of the country, will unleash a major onslaught against the masses in a bid to stem the tide of the rising numbers; use of a coercive, bureaucratic machinary against the people is also a logical outcome. People become 'targets' of their 'own government'. It is also logical that such a social relationship got support from many affluent countries and, through them, from some key international agencies. It is also logical that, despite employment of means which can be called into question, both legally as well as morally, the programme did not have the desired impact on the growth of population in the country. The deprived people have finally succeeded in resisting the coercive tactics adopted by the political - bureaucratic nexus.

Against this background the policy enunciated by the then Prime Minister in his inaugural address to the International Population Conference (Gandhi 1989) reflects

a refreshing change. It marks a watershed in the development of population policy in India. He has roundly disapproved the tendency to impose uniform norms 'determined monolithically by a central agency'. Instead, he has called for dividing 'the country into different zones where the relevant parameters are approximately homogenous, and adapt policies and programmes to the specific characteristics of these zones'. He has advocated a great degree of decentralisation in programme planning and implementation so that 'awareness, ethos and motivation are created more by the local neighbourhood than by some remote official agency'. He announced a plan to bring together different development programmes within a well-coordinated delivery system, with family planning being an integral element of this system. Such a system is to be linked with institutions of local self-government. He asserted that 'it is the nexus between development and its impact on the success or failure of family planning programme, more specifically, its effect on the life of women' that is of central importance.

Obviously, it would have required enormous efforts to follow up the policy pronouncements of the then Prime Minister to form concrete plans of action. In the first place, it would have needed a number of interdisciplinary teams of very high calibre to identify the zones where the relevant parameters are similar and formulate programmes which are specific to the conditions prevailing in them. A qualitatively different approach would have been needed to ensure decentralisation and to make the programme for population control an integral element of a well co-ordinated system which brings together the different development programmes. Then, there was the formidable task of dismantling the giant centralised bureaucratic machinary which has come into existence during the past three decades. Its place had to be taken over by an alternate, decentralized family welfare programme as an integral component of a co-ordinated system of development programmes. It would have required that there would be no sterilization targets laid down by a

central agency, no uniform pattern of organization to the followed everywhere in the country. If, as a management device, targets are to be used at all, these ought to be determined locally and they would cover the entire gamut of the co-ordinated development programmes, based on local conditions and available resources. This will also imply abandonment of the current propaganda drive packaged in the in the form of Information, Education and Communication - IEC. There would also have to be fundamental changes in the approach to evalution and research, leading to corresponding changes in the insitutions involved in these processes.

It was timely that the then Prime Minister and the Chairman of the Planning Commission should have made the policy statement on the eve of formulation of the Eighth Plan. First and foremost, implementation of this poilicy would have required a massive political and administrative mobilisation to repair the damage and place on the ground a carefully designed, revitalised programme.Considering the far reaching implications of unbridled population growth in the country, such a programme had indeed to be taken up on a 'war footing'.

The overthrow of the Congress (I) Government by the National Front in December 1989 provides an interesting footnote. It is difficult to visualise that the new government will oppose the fundamental issues raised by the former Prime Minister: decentralisation, debureacucratisation and identification of regional patterns. The moot question is: will this government have the political courage to implement these laudable ideas? Or, will they need yet another jolt from the deprived people before they are impelled to fulfil the promise they had made to the people in the Consitution in 1950? The publication of the Approach Paper to the Eighth Five Year Plan (GOI 1990) kindles some hope that there would be far reaching changes in the approach to population control in India.

CHAPTER TEN

NATIONAL HEALTH PROGRAMMES

Over the past decades, the various national health programmes have become almost a routine fixture of the health services of the country. Initially, the National Malaria Eradication Programme (NMEP) was expected to eradicate malaria from the country, once for all, by the sixties. That did not happen and there was a massive resurgence of the disease which led to what is termed as the Modified Plan of Operation (MPO) for Malaria Containment in 1976. This approach is still being followed and a substantial proportion of the plan outlay is still being allotted to this programme. As in the case of original NMEP, the research base of the MPO needs a great deal of strengthening to make the programme more effective. The efforts made thus far have been grossly inadequate despite all the commitments that were made at the time of the launching of the MPO (Banerji 1985a: 142-44).

The National Leprosy Control Programme, now called National Leprosy Eradication Programme, is following a similar trend ever since its conceptualisation some three decades back. Once again, epidemiological analysis concerning the natural history of the disease in the country and the strategies for intervention in the natural history are grossly inadequate (Rao 1982; Banerji 1985a: 144-48). Instead, of late, considerable enthusiasm has been built up in favour of technocentric approaches. Multi-drug therapy is the sheet anchor and a great deal of hopes are placed on the expected impact of the still to be developed leprosy vaccine

(WHO 1985a). While technological breakthroughs should on no account be ignored, it is equally important that the expactations from such technocentric approaches are subjected to careful scrutiny through close monitoring and evaluation of the programme. The sucessful demonstration of community involvement in leprosy diagnosis and treatment by DANLEP (1988), referred to on page 85, provides a promising direction for totally restructuring the now fossilised NLEP.

The National Programme for the Prevention of Blindness is also encountering problems because of problems of implementation of the rural health services. Here, once again, an extensive national programme was launched without making adequate efforts to carry out suitable operational research studies to optimise the system, as was done in the case of the formulation of India's National Tuberculosis Programme (NTP) (Banerji 1971).

Significantly, the failures to deal with the already existing felt need for tuberculosis services through NTP underlines the current state of functioning of the rural health services. As a result of extensive operational research studies (Banerji 1972), the NTP was so designed that it should sink or sail with the general health services. Thus, strengthening of the general health services is a pre-requiste for strengthening the NTP.

As pointed out earlier, the virtual breakdown of the public health system in the country (Banerji 1984a) is associated with frequent outbreaks of epidemics in different parts of the country: epidemics of kala-azar, Japanese encephalitis, pyogenic meningitis, cholera and gastro-enteritis, bacillary dysentery, infective hepatitis, and so on. Very little effort has been made to make a scientific investigation into these outbreaks. The responses have been of *ad hoc* character. It should have led to careful interdisciplinary operational research studies to draw up stratagies and programmes for

coping with such problems. The programmes launched to cope with the porblems of kala-azar and Japanese encephalitis fall in this category. The response to the problems of AIDS follows the same pattern. However, because of the enormous international interest and some degree of fear among the upper classes, disproportionately large allocations are being made for the AIDS programme (Banerji 1989a).

One of the outstanding aspects of the malady of the health service system of the country is demonstrated in the way the country has responded to the problem of simple goitre. The problem was identified in the mid-fifties. Its solution also is well known. However, despite all the clamour about it, it still remains a public health problem (Nutrition Foundation of India 1983). Significantly, there is now a good deal of publicity to the effect that simple goitre is spreading to new areas and that even a substantial number of children in the capital city are victims of this disorder. Have the scientists charted out the process of generation of iodine defficiency in the new areas? Have they tried to integrate the goitre control programme with an overall strategy for improving the health status of the people living in the goitre prone areas? The fact that such ideas have not emerged, in spite of the importance given to the programme, shows the quality of research support given to community health programmes in India. Expectedly, once again, a technocentric solution is being sought in the form of compulsory iodisation of all salt sold in the country. Arvindan (1989) has pointed out that such an drastic decision has been taken without considering important pathological, clinical, epidemiological and political issues.

The UIP is being analysed again because it provides valuable insights into the policy formation and implementation and strategy development and managerial process of most of the national health programmes in the country. The generalist administrators in the Union Department of Family Welfare

had formulated the Universal Programme of Immunization with considerable support from UNICEF, WHO, World Bank and many Western countries. This was presented as a 'living memorial' to the late Prime Minister Indira Gandhi (GIO 1985a). The programme was expected to cover all the vulnerable children by 1990. The recently published report on a National Review of UIP (Gupta and Murali 1989) has shown that the programme has ended in failure.

The Government of India has dovetailed the policies and strategies for UIP to those contained in its documents of the National Health Policy and to its strategy for attaining Health For All by 2000 A.D. (GOI 1985a). The basic policy assumption is that the six immunizable diseases account for a substantial proportion of infant mortality and morbidity in India and that an inexpensive and simple technology is available against these diseases in the form of immunization. UIP was therefore considered to be a most cost effective programme. Epidemiological, administrative and technological analysis of UIP reveals that the policy assumptions were not well founded. Being a programme which is thrust on the people from above, the policy violates the central premise of the National Health Policy and the Alma Ata Declaration on community participation and social control over technology.

The most glaring aspect in the plan of action for UIP is that it follows the same pattern — the 'Central Pattern' — in all the states of the country. What to speak of community involvement, virtually there is no involvement of the states in the planning process. A most distrubing consequence is that UIP is often branded as a 'Centre's Programme' by state governments (Banerji 1989b). It is passively accepted by the state governments. The acceptance by the people is also often passive. This causes major problems in the 'absorption' of UIP within state health organizations and within the managerial processes. The problems are particularly acute in states which are weak in organization and managerial processes. Finally, the plan of action ought to have been

based on data from operational research and systems analysis, which could have assured more effective use of the resources assigned for UIP.

The consequences of the flaws in the policy, strategy and plan of action were very apparent in the course of study of implementation of UIP in the State of West Bengal (Banarji 1989b). The state has a very rich heritage of health service development. However, there has been a very steep decline in the quality of managerial processes. Work culture has gone down sharply. The efficiency of the services is very low (West Bengal State Legislative Assembly 1988; 1989). Consequently, implementation of UIP has suffered materially at different levels of health administration in West Bengal. There have been problems in ensuring the supplies and in maintaining the cold chain; key personnel for UIP are still to be posted in most of the districts; there have been serious problems concerning the work of the multipurpose workers, anganwadi workers and village health guides; the outreach of IEC is inadequate to cover fully the most vulnerable segments of the population where UIP is most relevant.

Compared with the suffering caused by the various health problems that are generated by the highly unfavourable ecological conditions, that caused by the six diseases form a tiny fraction: a mere drop in the ocean. The most revealing finding of the study of UIP in West Bengal is that even if it were possible to completely eradicate the six diseases, it would have made only a marginal difference to the lives of the people.

For improving the situation, there is no alternative to the very difficult, long, grinding task of building health services which respond to the felt-needs of people by using people oriented technologies, as envisaged in the National Health Policy. It is the people — their felt-needs — who should have the last word, and not technology.

CHAPTER ELEVEN

HEALTH SYSTEMS RESEARCH AND HEALTH MANPOWER DEVELOPMENT

HEALTH SYSTEMS RESEARCH

One of the principal responsibilities of health administrators is to encourage research to develop optimal health service systems which ensure that the very limited resources available for health service development are effectively utilised. As is apparent from detailed discussion of different aspects of the health services system in India, the research covers a wide range of subjects: family planning; hospitals and medical care services; community health worker scheme; sub-centres; primary health centres and community health centres; formulation, implementation and evaluation of various national programmes; development of indigenous systems of medicine; community participation and health education: and so forth.

An enormous network of research institutions has been set up in India to deal with various aspects of the country's health problems (Pandit 1961). The Indian Council of Medical Research has been involved in such pioneering efforts as the National Sample Survey of Tuberculosis (Indian Council of Modical Research 1959), the clinical trials at the Tuberculosis Chemotherpy Centre (1959), Madras, and the BCG Vaccination Trial at Chingleput (Baily 1980), and a

number of research and evaluation studies on several other national health programmes.

However, considering the requirement, the role of ICMR in conducting research for development of health services in India has been extremely inadequate. It can be safely asserted that there have been very few programmes which have been built on the foundations of research inputs from the ICMR. Also, few of the other programmes have received research inputs from the ICMR which have materially improved their performance. This again reflects the research climate prevailing in the country. Efforts to promote excellence in health systems research has been conspicuously absent in most instances; the vacuum is filled by research of sub-standard quality, which at times becomes even counter-productive.

The Group on Medical Education and Support Manpower (Shrivastav Committee) had submitted, in the early seventies, an elaborate programme for immediate action which called for considerable research efforts (GOI 1975: 51-52). However, thus far, very little has been done in the field of research on health manpower development in India.

Similarly, the ICSSR-ICMR Study Group (1981) presented an alternative strategy for health systems research. More than nine years later there is little evidence that this had been followed up with concrete efforts, involving systematic research. To be sure, many research projects have been funded, but from the point of view of research design, few of them really maeasure up to the requirements needed for testing out the essential elements of the suggested alternative. This is yet another instance of a study which has provided the basis for the Union Government's strategy for providing health for All by A.D. 2000 without producing adequate data, and without support from properly conducted operational research studies.

In the absence of a strong commitment to health systems

research on sound lines, which is an essential requirement for studying a highly complicated health service system, there has been a tendency to adopt a rather simplistic approach to health systems research. The India Population Project - I (1973) is an example. Its cost ran up as high as US$ 30.8 million. It focused on what essentially turned out to be the child survival theory of population control. Apart from basic flaws in the conceptualisation of the problem and in development of the research design, India Population Project-I encountered basic problems in implementation (Maru et al. 1983). The net result has been that, thus far, scholars outside the government cannot get even a report of this very expensive experiment. However, a recent paper (Bergstrom 1982) has given indirect evidence of the failure of IPP-I to find answers to many of the questions it had set out to study. Unfortunately, IPP-I has been followed by what had been called IPP-II. This approach has been extended to fourteen other states in the form of Area Projects, with the express purpose of channelling aid from foreign countries. As pointed out by Ashish Bose (1988:342), because of serious flaws in the project design, the Area Projects have singularly failed to attain the objective set for them.

HEALTH MENPOWER DEVELOPMENT

The trends in the manpower development in the country in terms of the type of personnel and in terms of qualitative and quantitative aspects of training, reflects the real crisis in the health service system in the country. At first, health manpower development was considered synonymous with the production of physicians. Subsequently, while following the same principle, some efforts were made to bring about social orientation of medical education. It is only later that attention was paid to the production of other key elements in the health manpower such as nursing personnel, technicians of various kinds and other paramedical workers.

Apart from very serious questions of the numbers in production, there is the still more critical problem pertaing to

the quality, particularly considering that the National Health Policy calls for a fundamental departure in the approach to manpower development. The task was even more challenging, because of the entire manpower requirement was to be visualised in terms of development of people oriented health programmes and health services in the country. It is essential that the manpower development should have taken place in consonance with the nature of the health service system as formulated on the basis of health systems research. WHO (1985a) had termed it as health systems research for manpower development (HSMD). Understandably, as so little of health systems research input has gone into massive national programmes such as the Community Health Workers' Scheme, Multipurpose Workers' Scheme, Area Projects, Family Welfare Programme, Modified Plan of Operation for Malaria, expansion of rural health infrastructure and the Universal Programme of Immunization, it literally ruled out any possibilities of a sound health manpower policy or strategy. The approach to education and training of various categories of health workers has also been very casual and ritualistic (Banerji 1985a: 77-80).

The time-honoured indices of doctor-population ratio or nurse-population ratio are of limited significance. The norms adopted for these are open to serious question. Besides, if one must use such ratios, they must be population and region specific: what are the ratios in metropolitan cities, as compared to smaller towns and villages? what are the ratios in economically or socially advanced regions, as compared to those that are backward? and so on.

Also, indices of manpower development should not revolve merely round the number of physicians and nurses. At best, the number of these professionals is relevant for hospitals where they have key roles. In a country where a very big proportion of activities of the health services takes place outside hospitals, the indices should embrace a much wider range of professionals and supporting staff.

In addition, manpower development demands promotion of team work. This brings into focus the vital question of the quality of education and training received by community health personnel, health professionals, and the supporting staff. Socialisation of personnel in cloistered hospital settings during their education and training is inimical to the type of work they are required to do at district and taluk hospitals, PHCs, sub-centres, dispensaries and villages. Finally, manpower development of a Third World country like India must be studied in terms of the rate of growth, rather than in terms of absolute numbers.

As has been mentioned earlier, soon after the country gained independence, a reorientation of medical education and training was attempted through establishment of upgraded departments of preventive and social medicine in medical colleges. In the three decades since then, sustained efforts have been made to carry this reorientation process forward. A number of commissions have sat and a number of national conferences have been held to stimulate this process.

Taking note of past experience, the Shrivastav Committee (GOI 1975), which examined medical education in the context of the reorganised health services, submitted in April 1975 a programme for immediate action. Against a background of the need (a) to relate the problem of health to poverty; (b) to provide training in health services to community representatives; (c) to strengthen primary health centres; and (d) to develop a referral service complex, the Group made many far-reaching recommendations concerning the basic content, structure and process of medical education. Essentially, the group was for the creation, by an Act of Parliament, of a Medical and Health Education Commission (patterned on the University Grants Commission) charged with the responsibility of determining and implementing a radical programme of reform in medical and health education, and with functioning as an apex coordinating agency in close

and effective collaboration with the statutory national councils on health professions.

The Shrivastav Committee emphasised the need for in-depth discussions and taking of concrete steps for 'immediate, vigorous and sustained implementation' in tackling important issues. These included: determining of objectives of undergraduate medical education; giving it a positive orientation; reorganising pre-medical education; revising the undergraduate curriculum, including training of teachers; production of teaching and learning materials; adopting suitable teaching and evaluation methods and creating necessary physical facilities; reducing the duration of the course while ensuring improved standards; reorganising the internship programme, post-graduate teaching and research and continuing education; and, research and evaluation of health manpower needs.

Despite all the exhortations of the Shrivastava Committee and the ICSSR-ICMR Study Group for immediate action, it is apparent that the quality of medical education in particular and the health manpower development in general has continued decline sharply (Banerji 1985a : 87-91). This was underlined in the statement on the National Health Policy and in the Seventh Five Year Plan (GOI 1985b)

The fact that the quality of health manpower development has not shown much improvement despite these efforts points to the need for understanding the problem in its social, cultural and political contexts. These dimensions have been overlooked by the committees which had examined this area.

One of the ironies of India's medical education system is that community resources are utilised to train physicians who are not suitable for providing services in rural areas, where the vast majority of people live and where the need is so desperate (Banerji 1975). By identifying itself with the highly expensive, urban and curative-oriented Western system of medicine, the ethos of medical education in India actively

encourages physicians to look down on existing facilities within the country, particularly in rural areas. Thus, physicians look for jobs abroad, causing the so-called brain-drain.

On the basis of the foregoing consideration, it is possible to identify the major tasks in manpower development for primary health care:

1. As an integral component of health systems development, health manpower development becomes a sub-system of the bigger system and interacts very closely with the other major sub-systems, namely the community, the nature of community health problems and the technologies that are chosen to deal with them. In other words, those engaged in health manpower development will have to be members of an interdisciplinary team for health service development. Their task will be to formulate strategies, plans and programmes for manpower development on the basis of an understanding of the other sub-systems. Reciprocally, those engaged in developing other sub-systems of the health services will have to take account of the need for health manpower development.

2. The community is the main focus for health manpower development. Health personnel are required to offer technologies which are practical and effective under the conditions in which the community lives and within the resources it can afford. This is quite different from the earlier concept of a health worker dispensing a 'standard' technology only to those who are able to acquire it.

3. To meet the health manpower requirements for primary health care it is now necessary to produce a much wide variety of personnel. It is not enough to produce conventional health professionals and some auxiliaries who are trained specifically to assist these professionals. The induction of a very large number of community level health workers and the association of practitioners of indigenous systems of medicine

and other traditional healers and birth attendants into the system has given an entirely new complexion to the manpower profile for primary health care.

'Going to the people and learning from them' is a basic postulate of primary health care. The methods and concepts of the social sciences provide the mechanism for doing so. It will be necessary to produce anthropologists, sociologists, political scientists and economists, who, as members of interdisciplinary teams, would be able to assemble data, analyse them and provide guideance on social, cultural, political and economic matters for the health services.

4. Another major task is to produce the different categories of personnel in adequate numbers. This requires major administrative efforts. Competent personnel will be needed to manage the very big and quite complicated programmes.

5. The considerable expansion of the health services system and induction of new types of functionaries call for basic changes in the administration. Qualitatively different types of managerial personnel are now required who are able to integrate the different categories of personnel within a people-oriented administrative framework. They are also expected to play a much more active role than hitherto in promoting intersectoral action. There has also to be a considerable increase in the number of such managerial personnel.

6. Development of personnel for conducting health systems research and research on manpower as an integral component is another critical area.

CHAPTER TWELVE

SOME OTHER HEALTH ACTIVITIES

HEALTH EDUCATION

It is well recognised that the conventional approach to health education, which attempts to bring about motivational manipulation of people, so that they conform to certain patterns of behaviour dictated by programme administrators is not only counter-productive but downright immoral (WHO 1983a). Unfortunately, in India, this approach has been used extensively. The presumption was that the people are ignorant and they are seeped in cultural traditions which are not desirable. With these obvious value positions, health educators have sought to bring about behavioural changes among the people. Understandably, making people accept sterilisation has been by far the most important area for 'health education'. Predictably, this approach has failed miserably. In spite of building an enormous organisation to impart health education in India, there are very few instances of success stories. Health education organizations are becoming a drain on the country's very limited resources. An approach, which involved an understanding of the people and developing people oriented health programmes and playing of advocacy role for the people, should become the basic foundations of the alternative approach to the content, practice and research in health education. (WHO 1983a).

VOLUNTARY AGENCIES AND COMMUNITY PARTICIPATION

There seems to be a good deal of wishful thinking about the nature of the voluntary agencies and the extent of their role in health service development in India. Who are the so-called voluntary health workers? What motivates them to undertake so-called voluntary work? What are their academic credentials? What is their class background? What is the source of funding? How vulnerable are they to various economic and political vested interests, both within the country and abroad? What is the degree of community contributions to the so-called voluntary health work? Why should they ask for government help if they are really voluntary organizations? What innovative ideas have they developed in the field of health? Answers to such questions will raise the still more fundamental questions about the political economy of voluntarism in India. Voluntarism itself is tending to become a lobby of certain class elements (Kothari 1986; Karrat 1989).

Considering the population they are covering in India, they cater to a very tiny fraction. They are scattered and their distribution is also skewed towards urban and peri-urban areas (Jesani, 1986). It is obviously unrealistic and unfair to assume that voluntary agencies can play a major role in ensuring community participation in health and family welfare programmes in India. Institutions such as the Family Planning Association of India, which depend on funds from abroad or Indian business houses do not inspire confidence about their taking the side of the people, particularly the unserved and the underserved.

The Universal Immunization Programme included a major role for voluntary agencies. However, an assessment (Gupta and Murali 1989: 41-44) has once again shown that when it comes to actually contributing to a national programme, they give a miserable account of themselves. The experience is similar in the field of other national programmes.

INDIGENOUS SYSTEMS OF MEDICINE

This is another area which has been subjected to considerable lobbying. Less than realistic visions are conjured up concerning their contributions to health service development in India. Even the very limited action that has been initiated in these systems has now made it quite apparent that much more attention needs to be paid to strengthening the curriculum content of education in the three principal systems of medicine, in developing competence of the teachers, in strengthening the professional colleges and in attracting better quality of students. There is also considerable need for field experimantation to determine the effecacy of the systems of medicine in relation to the prevailing folk medical practices, on one hand and Western medical practices, on the other.

The fact that the institutions of the Indian Systems of Medicine have not been able to attract good scholars and students shows that much more groundwork needs to be done in developing these institutions. As has been repeatedly pointed out in Chapter Six, people in rural areas very deliberately reject the indigenous systems. The village Rohat in Pali district in Rajasthan has both PHC dispensary and an Unani Government Dispensary and the choice of the villagers is overwhelmingly in favour of the former (Banerji 1982: 300). Ayurvedic vaids are now frequently found using antibiotics, steroids and injections. Ironically, however, it is the city elites who are going back to the indigenous systems: those covered by the Contral Government Health Scheme had insisted on opening of Ayurvedic, Unani and Homeopathic Dispensaries under the CGHS !

TRENDS TOWARDS PRIVATISATION OF HEALTH SERVICES

As has frequently been referred to earlier, one of the most undesirable outcomes of the neglect of some of the crucial areas of health services in the country is that it has left

considerable felt needs and demands of the people unmet. This has generated a rapidly expanding market for the private sector. At one extreme, this takes the form of proliferation of the so-called Registered Medical Practioners or quacks. At the other extreme is the recent trend in the development of a corporate sector in the field of high technology oriented medical care. Ironically, as if the neglect of their duties towards maintaining and promoting the health of the community is not bad enough, some sections of the political leadership is actively lobbying for the entry of private sector in high technology medicine and they are even prepared to advocate government participation in joint ventures with them. This marks a new low in the abdication of the responsibility of the government towards the vast masses of the people. It is a cruel joke that while literally millions of people are allowed to die of the most elementary preventable diseases because of the inaction by the government, the same government ties up with captains of industry to develop joint ventures to cater to high technology needs of the wafer thin uppermost class of the population of the country.

There is also an increasing pressure from an influential section of health administrators to levy charges from people for 'services' given at government health institutions (Editorial Comment 1988). 'No free lunch', they exclaim. This, they contend, is the only way to meet the ever rising cost of health services. But these people do not ask the most logical of the questions in this connection: which section of the society will benefit from the high technology-based services built up by levying the charge on poor people? Anyway, whose money is government money? Who will profit from the sale of high technology equipment? Incidentally, the 'health insurance' plan represented by the Central Government Health Scheme provides a startling example. Even the richest section of the beneficiaries pay a tiny fraction of the ever increasing cost of the services provided by the CGHS. Added to that, the 'services' are poorly planned, still more poorly managed and therefore exeedingly wasteful. So, to subsidise such wasteful

and extravagant ventures for the privileged, the poor must be charged for the miserable services they get at PHCs, the taluk and district hospitals and in the larger city hospitals, which have become literally 'murderous' dungeons of diseases as graphically clascribed by the Lentin Commission on the JJ Hospital in Bomaby (Government of Maharashtra 1986) and the recent tragedy in the 'venerable' Medical College Hospital in Calcutta, where newborn children had to pay with their lives, because sheer carelessness led to outbreak of tetanus in the maternity wards of the Nilratan Sirkar Medical College Hospital and their closure created a rush for the Medical College Hospital (Mukhopadhyay 1989).

In between the two extremes, again, responding to the unmet felt needs, there is also proliferation of large number of private clinics, nursing homes and diagnostic outfits. These are serious danger signals for the people of the country.

CHAPTER THIRTEEN

THE ICSSR - ICMR REPORT IN RETROSPECT

With the hindsight of over nine years, the ICSSR—ICMR Report can be seen to be providing interesting sociological insights into the nature of health service development in India. The ICSSR took the initiative in bringing together renowned persons from different fields to join the Study Group and work as an interdisciplinary team. It was *not* a government sponsored group. Indeed, it had sought some financial support from the Family Planning Foundation (1983) created by the Ford Foundation and some of the captains in the private sector in India. As pointed out earlier, following the not so effective 'committee approach', along with commissioning of certain working papers, the Study Group came out with its Report which ventured to cover the entire field of health service development against the much wider social, economic and political setting to evolve what it termed as 'An Alternative Strategy' for providing Health For All.

From what has been described in the preceding chapters, one can see a wide gulf between the summary account of the ICSSR-ICMR Report (Chapter Three) and the analysis of the policies and programmes given in the following nine chapters. This is because *the Report did not discuss the basic political, economic and social forces which shape the health and family planning policies and programmes in India.* It was an apolitical and an ahistorical Report. For instance, it had stressed that

the success in implementation of its recommendations 'will be proportional to the extent to which it is possible (i) to reduce poverty and inequality and spread education; (ii) to organize the poor and the under-privileged groups so that they are able to assert themselves; and (iii) to move away from the counter-productive, consumerist Western model of health care and to raplace it by the alternative model based in the community as is proposed in the report'. There is thus an overt contradiction between technocentric recommendations concerning the 'alternative model' on one side and call for fundamental social, cultural and political action to create the essential conditions for its implementation, on the other. It was as unrealistic to expect reduction of poverty and inequality, spread of education, organized assertion by the under-privileged and demolition of the Western model, as it was to expect substantial outcome from the numerous recommendations concerning the various programmes. *The Report is a peculiar mix of utopian social and political expectations and simiplistic analysis and recommdations for specific action.*

Furthermore, key issues such as quality of practice and research in public health and increasing dominance of generalist administrators were virtually overlooked in the Report. Even more surprising was the omission in an ICSSR-sponsored report of basic community issues in health service development: there was little of grass roots data on the underprivilaged in a report which had set out to recommend and 'alternative model based in the community'.

Against this background, it is all the more significant that the Report should have directly influenced three basic decisions of the Union Ministry of Health and Family Welfare: the Statement on National health Policy; Strategy for Health For All by AD 2000 (GOI 1981); and extensive expansion of the rural health service infrasturcture by converting the existing PHCs into Community Health Centres (CHCs) setting up a New PHC for 30,000 population and a sub-centre for 5000

people. Only later it was 'discovered' that there was confusion in the supervision of the sub-centre: the single physician in the New PHC cannot supervise the six sub-centres within its area: nor was it possible for the CHC to supervise the more that twenty sub-centres. This is a typical example of the poor quality of decision making within the Union Ministry of Health and Family Welfare and within the Planning Commission. The ICSSR-ICMR Study Group simply did not attempt to a anticipate such situations.

Even a cursory glance at the Report reveals that efforts of the Study Group has fallen far short of requirements. There are gross shortcomings in their investigations, in their diagnoses, in their prognoses and, last but most important, in their prescriptions (Banerji 1981). Development of a strategy for health for all requires an epidemiological approach for making community diagnoses and for developing an optimal package for technological interventions in the natural histories of different health problems, in order to make the maximum epidemiological impact on the problems. The report provides numerous instances of the Study Group not having shown enough sensitivity to the epidemiological issues involved in solving community health problems. Because of this, in many cases, it has ended up making assertions which do not stand scientific scrutiny. That the top names in various aspects of community health have proved to be much less than adequate in formulating a plan of action to improve the health status of the people of India is an indication of the depth of the crisis facing India's health services today. As the task of evolving a strategy for providing health for all the people of India by A.D. 2000 requires optimisation of a highly complicated system, the old British method of 'forming a committee to look into the problem and make recommendations' is hardly the best method of choice.

However, the report does contain some very refreshing and categorical pronouncements. It makes the unequivocal pronouncement that the entire question of health is

intertwined with wider questions related to social, economic, political and cultural development of society and that intense efforts in the health sector should have a backdrop of simultaneous, complementary and mutually supportive efforts in (i) socio-economic-political transformation, (ii) family planning and (iii) interrelated fields like nutrition, improvement of the environment, and health education (ICSSR-ICMR 1981: vi-vii).

Similarly, by endorsing the recommendations of the Planning Commission Working Group on Population Policy (GOI 1980), it firmly takes the view that family planning can be meaningful only if there is concurrent socio-economic development, particularly improvement in the status of women. The Study Group also totally rejects all forms of coercion and monetary enticements. The Group is equally categorical in relating the nutritional problem to the problem of employment, social justice and democratisation, which influence the purchasing capacity of the people. The Group recognises that in the existing social structure, a small elite controls disproportionately large political and economic power and this poses a major obstacle to ushering in a more equitable health care system. The Group is also quite outspoken about promotion of self-reliance among people by bringing about greater decentralisation and democratisation of health service organizations and demystification of medicine.

Though these pronouncements have not been made for the first time, the fact that a Group which enjoyed so much prestige had come out so categorically on these important issues is itself of considerable help in debunking the conventional wisdom that had dominated the health field for such a long time.

Unfortunately, as the analysis of the policies and programmes presented in the preceding nine chapters shows, these laudable pronouncements have not been carried to

their logical conclusions in the form of more specific action programmes. The Study Group has also ended up making many recommendations which are diametrically opposed to some of the pronouncements referred to above. For example, on one side, they have pleaded for community self-reliance, respect for peoples' autonomy, and promotion of democratic values; on the other, they have pleaded for establishment of a Population Commission by an Act of Parliament 'to formulate and implement an overall population policy' (p. 148). Their ahistorical approach is revealed from the fact that they wanted (in 1981) India to join the league of dictatorial countries, which had population commissions: Ayub's Pakistan, Marcos' The Philippines and Suharto's Indonesia.

A direct involvement of the ICSSR-ICMR Study Group in the decay and the degeneration of the health services in the country during the past decade can be traced to their failure to take into account some of the critical issues in health service development in the country. Some of these critical issues are mentioned below:

1. They have neglected to pay attention to the critical role of high competence in public health practice needed for implementation of the many recommendations made by them.

2. They have not been able to make in-depth analysis of some of the key public health programmes of the country. Because of these failures, they have ended-up in making simplistic recommendations concerning highly complicated areas which require high degree of interdisciplinary competence (e.g. leprosy, ICDS, malaria, filaria).

3. One of the glaring shortcomings in the Report pertains to the failure of the Study Group to analyse the relationship between the generalists and the specialists in health ministries and departments. They did not realise the critical role of the cadre

structure in the implementation of the health programmes.

4. Recommendations to have Acts of Parliament to create a Population Commission and a Medical and Health Education Commission reflect their tendency to find authoritairian solutions to the problems, notwithstanding all their commitment to democratic norms and concern for promoting community self-reliance.

5. Even though the ICSSR was the moving spirit behind the Report, one finds very little political and social analysis of the health service development and very little of use of these considerations in making recommendations concerning rural health services.

6. One glaring shortcoming is that while the Study Group talked so strongly about deprefessionalization and decentralization, it did not find any contradiction in favouring the promotion of community health workers as paramadics, even as doctors!

7. The Study Group seemed to be oblivious to issues concerning glaring regional imbalance in health services in India.

It can thus be concluded that while the ICSSR - ICMR Report received more than its due attention from the government authorities in the formulation of policies, strategies and plans of action, some of its key recommendations have been grossly distorted or even unceremoniously ignored in pushing through target - oriented, time-bound programmes like family planning and Universal Immunization Programme. Its acts of omission and commission in taking up critical issues in public health practice and research certainly contributed to the steep decline in the quality of public health practice in India.

A recent comparision of the ICSSR-ICMR Report with the Report of the famous Bhore Committee by a scholar, who happened to be the secretary of the ICSSR-ICMR Report (Antia 1990), should provide an apt footnote to this chapter. He has observed that the ICSSR-ICMR Report has not been based on such extensive information, nor has it the width of vision or provide the detailed recommendation, as in the Bhore Committee Report.

CHAPTER FOURTEEN

OVERALL CONCLUSION: CRISIS IN THE MEDICAL PROFESSION IN INDIA

The medical profession in India is in the midst of a profound crisis. This crisis has percolated deep into most of medical and health institutions and organizations. The morale of the medical personnel seems to have touched a new low. This crisis has been brewing for a considerable time. One reason for the sudden outburst is that hitherto a sustained effort had been made to cover it up through deliberate neglect of collection of some key information, active suppression and distortion of information, indulging in cheap propaganda gimmicks and spread of disinformation. However, the situation has now worsened to such an extent that it is no longer possible to keep the lid on. Three categories of symptoms of the crisis are presented below.

One manifestation of the crisis is in the form of the sharp increase in the number of strikes by physicians. The deplorable service conditions and the refractory attitude of the authorities has precipitated the present situation. At first, there were frequent outbreaks of strikes by junior doctors in teaching hospitals for higher emoluments. Junior doctors have also resorted to frequent wildcat strikes to express their resentment against various issues. More ominously, the cult of strike has now spread to the government health service cadres. There has recently been a protracted strike by physicians in the Union Government. Similar

strikes are now becoming commonplace in the states. The principal demands of the striking physicians are increased emoluments, better promotional avenues and better status for physicians in government organizations.

Another indication of the crisis of the medical profession in India is manifested in the form of a sharp decline in the ethical standards in the practice of medicine. These were dramatically brought into focus during agitations in Maharashtra on the issue of deaths due to use of contaminated intravenous fluids in the venerable JJ Hospital and serious allegation of irregularities in the award of a doctoral degree in medicine to the daughter of the then chief minister of the state. The Government of Maharashtra was forced to set up the two famous Lentin Commissions. These two commissions have given a graphic account of the very sorry state of affairs prevailing in the two premier institutions in the country, namely, the JJ Hospital attached to the Grant Medical College and the quality of postgraduate medical examinations being conducted by the University of Bombay. The setting up on the so-called capitation fees based medical colleges in different states provides an instance of demonstration of the awesome power of some affluent sections of the community to impose their will on governments. Even those who cannot remotely qualify for admission to medical colleges can now do so if they have the money to pay the price. This, in fact, is a mere facet of the widespread trend towards commodification of medicine over the past several years. Practice of medicine is now becoming a commercial activity. Like their counterparts in other commercial fields, physicians are now getting away with gross professional misconduct and negligence, even when they are held responsible for avoidable deaths, deformities and suffering to the patients who have literally entrusted their lives to them.

The gross maladies which were identified by the Lentin Commission on the JJ Hospital are also extensively prevalent in the entire hospital and medical care system of the country.

The decline in the quality of services provided by hospitals at district, taluk and primary health centre levels is even steeper than what is observed in the bigger hospitals located in cities. There is also a very sharp decline in the quality of performance of physicians in the primary health centre (PHC) and other rural health facilities. Their reluctance to serve in rural areas is quite understandable. This has been a longstanding problem before health administrators of this country. However, of late, the deterioration in the quality of their performance has been particularly alarming. There are now many more cases of professional misconduct, professional negligence and corruption. There are increasing instances of non-practising physicians posted in rural areas who blatantly indulge in private practice – even within the PHC dispensary itself. Many do not hesitate to sell medicines belonging to the PHC. There are instances of PHCs which remain locked for days together, while the staff continue to draw their salary. A large number of the physicians do not stay in the PHC village. Many pay no heed to the prescribed timings.

The cummulative effect of the numerous shortcomings in the medical profession in India is the virtual breakdown of the public health system. During the colonial days there were public health specialists (belonging to the Indian Medical Service) who had a reasonably good information system to get to know about outbreak of epidemics. They also had competence to promptly investigate these epidemics and take appropriate anti-epidemic measures. This competence has now virtually disappeared. There is now a virtual 'epidemic of epidemics' in different parts of the country: epidemics of kala-azar, Japanese encephalitis, pyogenic meningitis, cholera and gastro-enteritis, bacillary dysentery, infective hepatitis, and so on (Editorial 1990). Investigations of these epidemics are often of a very casual nature. Anti-epidemic measures adopted are more of the nature of public relations exercises than as secientific campaigns to cope with with epidemics.

The recent outbreak of epidemics of cholera and gastro-enteritis in Delhi (p. 97) gives a telling example of the existing state of affairs. Similarly, when the epidemic broke out in tribal areas in South Bihar, it took a long, long time even to realise that such an epidemic has broken out. This is because even though an elaborate network of rural health services exists on paper, there is virtually nobody to take cognizance of outbreak of any epidemic, what to speak of taking anti-epidemic measures. The Bhopal Tragedy is designated as the worst industrial disaster in the world. However, so inefficient has been the response of the medical profession to the disaster that some of the most elementary epidemiological data concerning the disaster were not collected by the concerned authorities. A newspaper report (The Statsman, Delhi, Aug. 5, 1990) says that there were 3672 cases of meningitis and 104 deaths in Phulbani district in Orissa in the last 18 months. In Bolangir district, a 'strange fever' has caused 120 deaths in the past three months.

There are two major factors which can account for the present crisis in the medical profession in India. One concerns the quality of medical education. The standards of medical education has been allowed to slide down at an alarming pace. The physicians that are churned out of the country's 140 or more medical colleges are of a very low level of competence. Soon after independence, an effort was made to bring about social orientation of medical education by upgrading the then moribund departments of public health. However, this move failed to yield the desired result. The so-called upgraded discipline of preventive and social medicine now finds almost a bottom position in the preference hierarchy of medical students. Post-graduate education has also expanded very rapidly without adequate attention to the quality. The result is that these days the country is turning out over 13,000 medical graduates and over 10,000 postgraduates of various kinds, most of whom do not conform to the prescribed standards.

Production of so many sub-standard physicians has far reaching implications. Not finding any other outlet, many of them are simply forced to take up jobs in central and state government health services. In the government set-up they are assigned a relatively low status. There is thus a vicious circle–low level of competence and low status in the services.

However, it is well known that in spite of the rapid expansion, there is very stiff competition among candidates to get into medical colleges. Medical colleges thus get the cream of scholars. However, in the course of their five to seven years of socialization in obviously sub-standard medical colleges, most of them fail to grow scholastically as well as professionally. Some of them actually degenerate and deteriorate in the course of their medical education. Joining government health services as a Class-II officer implies long spells in rural areas. There is the considerable hardship of frequent transfers. The family suffers considerably because of lack of basic civic amenities and educational and recreational facilities.

Here then is the crux of the crisis in the medical profession in India. Medical colleges attract some of the brightest scholars of the country. However, these colleges fail to provide them with the appropriate quality of education. Many of the graduates and post-graduates are forced to join government health services where the conditions of work and conditions of service are most unattractive. This breeds frustration and various forms of corrupt and unethical practices. On the other hand, the same government organization offers much better service conditions and status to those belonging to the Indian Administrative Service. Here is a case of a candidate who might have failed to get admission into a medical college, but somehow manages to get into the IAS. Within five years of his joining the service, he becomes a deputy commissioner of a district. By virtue of that position, he writes the confidential report of the district chief medical officer, who has been in service for over twenty years

and who has under him over 200 physicians. How is it that a physician, who competes successfully and goes through long, grilling teaching programmes in medical colleges, is condemned by the government to spend long years in remote rural areas as a Class-II officer, while it showers so much status and prestige on those who have managed to join the IAS? This fundamental injustice to physicians, as compared to those in the administrative services, is at the root of the present sickness in the health service system of the country. The situation was quite different during the colonial days. Then the physicians had the all-India cadre of the Indian Medical Services (IMS), as a counterpart of the Indian Civil Services (ICS). The IMS was abolished at the time of independence, without replacing it with an alternative all-India cadre, as was done with the ICS.

The picture is indeed very grim. The political leadership, the leaders of the medical profession — teachers, researchers and administrators — and the generalist administrators, must be held responsible for bringing about such a decay and degeneration in the medical profession. It is worth noting that India has produced few, if any, health ministers, at union or state levels, who have shown any degree of imagination to build up the health services. The fact that one has to invoke the name of Shri Raj Narain (who was responsible for laying the foundations of India's national health policy and who put on the ground a programme which was meant to put "peoples' health in peoples' hands" by using community health volunteers), as the most noteworthy among the health ministers, speaks volumes of the quality of the political leadership of health ministers after independence. Exercise of patronage and nepotism, corrupt practices and grossly unjustifiable interference in the day to day working of health institutions and organizations have been the hallmark of their activities. Frequent changes in the leadership of the Union Ministry of Health and Family Welfare during the past four years, involving replacement of one political light weight or a political discard by another, shows how serious the

politcal leadership at the highest level is about issues concerning health and welfare of people and about the rapid increase in population growth.

Again, conforming to the prevailing social situation and the power structure, as a group, leaders of the medical profession almost willingly bartered away their sacred trust for personal gains. This abdication of responsibility at the political and professional levels of leadership left the field free for generalist administrators to further expand their power base. The result is the catastrophic crisis in the medical profession.

The situation has now become so serious that it will become increasingly difficult to cover it up by indulging in cheap propaganda gimmicks. There lies some 'hope' for the long suffering hundreds of millions of people of the country. Time is not far off when the authorities concerned will be impelled to take steps to repair the damage they have inflicted on the medical profession. The political leaders will be impelled to curb their own corrupt practices and interference in the functioning of the health services. They will also have to mobilise a different kind of professional leaders who can improve the quality of medical education, including its social orientation and rejuvenate the existing institutions for education, training and reserach in the fields of community health and get together health administrators who can provide effective leadership at different levels. This is a challenging task. But, it will become increasingly difficult to shirk it. The political leadership will also be impelled to take action to redress the very legitimate grievances of health service physicians about promotional avenues, salary structure and administrative status. If an IAS officer can become a deputy commissioner after five years of service, why cannot a physician, who has successfully competed in tests which are designed to be similar to that of the IAS, be entitled to be a district chief medical officer after a similar period of service? And, why should his work be judged by the

deputy commissioner? The solution to the present crisis in the medical profession lies in a thorough rejuvenation of the entire system of education and training of physicians on one hand, and offering them service conditions that are consistent with their educational background and social relevance, on the other. On the political leadership thus lies the responsibility of initiating action to solve the very serious crisis in the medical profession.

CHAPTER FIFTEEN

SUGGESTIONS FOR STRENGTHENING OF HEALTH PROGRAMMES

A large number of suggestions almost logically flow from consideration of the issues related to the weaknesses in the health service of the country discussed above. The Universal Programme of Immunization, the goitre control programme, regional disparities, formulation and implementation of programmes related to kala-azar, Japanese encephalitis and AIDS, health education and indigenous systems of medicine, are some of the example.

As pointed out in Chapter Eleven, dealing with areas in a fragmentary mannar will not be adequate. Such elements have to be considered as components of systems, sub-systems and sub-systems. It will be much more important to consider strengthening of the system as a whole. That will require a systems approach. The key variables in the system, which form the critical points in its functioning, have to be identified. In the context of the foregoing discussion, four such critical areas are identified: (1) Strengthening of the top leadership of health administration at the union and state levels. (2) Development of more optimal systems for programme implementation. (3) Drastically restructuring the family welfare programme. (4) Curbing the interference of generalist administrators in technical aspects of health services development in the country.

One major requirement for a systems approach to the strengthening of health services is that the interventions are done in a package form. It is almost an 'all or none' situation. The elements of this package is very briefly deseribed below.

A key requirement will be the strengthening of the public health competence of health administrators of the country. Obviously, it should start from the top level leaderships at the union and states levels. Then it will percolate the 'line' constituents in the health organizations. Optimisation of health programmes will require interdisciplinary operational research studies involving formulation of a number of alternatives, forecasting their suitability, with or without the use of epidemetric models, identifying the optimal solution and testing them under real, live conditions.

It is equally important that these changes are associated with basic changes in the cadre structure of health administrators all over the country. Health administrators should get remuneration consistent with their competence and capabilities, as compared to other cadre systems. They should also have promotional avenues appropriate to their qualifications and social relevance.

Correspondingly, the role of the generalist administrators should be strictly confined to the areas where they act as a link between the health administration as a whole and the political system.

The family welfare programme has been singled out specifically because it not only absorbs such massive resources, but also because it has caused so much of 'disturbances' within the entire fabric of the health service system of the country. The fact that, despite all this, it has failed to attain the objectives set for it, is yet another weighty argument in favour of its basic restructuring. While this in itself is an enormous problem, broadly it can be argued that there is a strong case for a drastic cut in the outlay for family planning in the Eighth Plan. This cut can be as much as 50

per cent of the allocation for the Seventh Plan. These cuts need not be made on a pro-rata basis. Even a quick review of the programme can show that there are areas which can be drastically pruned. Incentives, research, training, mass publicity are some examples which deserve severe cuts. One can also experiment with doing away with the target system. This tallies well with the former Prime Minister's proposal for a decentralised approach, with family planning becoming an integral element of a development pakage.

Fortunately, India has a rich heritage of health service development: a tradition of a sound approach to public health practice, an all-India cadre of health services and an organisation which was involved in operational research studies concerning an important health problem. The principal task now is to retrieve those traditions and to build on them to come to grips with the challenge of strengthening the health service of the country. More specifically, it would be in the form of rejuvenation of institutions, such as the All India Institute of Hygiene and Public Health, National Institute of Health and Family Welfare, National Institute of Communicable Diseases and National Tuberculosis Institute.

The pivotal question then will be: how to bring about the rejuvenation of these health institutions? How to build up a suitable cadre? How to roll back the influence of generalist administrators on technical matters in health and family welfare? The obvious answer is that this action has to be taken at the political level. It is the political leadership, taking up the cause of the suffering masses of the country, who have to get together a critical mass of very competent scholars and administrators who can rejuvenate the health institutions of the country and in this process strengthen the top leaderships. That will lead to a trickling down effect.

Similarly, with the experience of the National Tuberculosis Insitute providing the platform for developing optimal National Tuberculosis Programme for the country, it is possible to

visualise similar action in many other programmes, including the Universal Programme of Immunization. Once the research and administration components of the health services are thus strengthened, it would be essential to drastically curb the influence of the generalist administrators on the health services of the country.

CHAPTER SIXTEEN

AFTERWORD

The preceding chapters document an effort to study and treat sickness of our health service system. Health policy analysis is considered to be a political process, as a socio-cultural process and a technological and managerial process, with their own epidemiological and sociological perspective . Analysis of health programmes have also taken into account these major dimensions and extended them into at least four major categories of variables which intimately interact with one another: community considerations; epidemiological considerations; the packages of technology chosen for specific health problems; and the health care delivery systems at different levels of organisations, starting from the village going right up to the highest level.

This involved study of the etiology of the sickness of the system, its pathology, its symptoms, its signs, its diagnosis and its treatment and prognosis. The articulation of the ideas presented in this book is the outcome of sustained efforts that have made by a large number of scholars of health administration in India over a period which extends at least to seven decades. Because of its special characteristics, it has been called New Public Health, to distinguish it from the conventional knowledge of undergraduate and postgraduate public health used in most institutions in this country and abroad. The ideas presented in this book have survived and even flourished because of their relevance to the problems that are actually observed on the ground: namely the problems of the sickness of the health services system. The

conventional health approach have proved, time and again (eg. the Mudaliar Committee Report or ICSSR-ICMR Report), to be inadequate to cope with the sickness.

This is the justification for using highly complicated inter-disciplinary concepts and methods in the book. Admittedly, this makes it a very hard reading. This could not be helped, because dealing with the sickness of a health service system itself is such a complex process. Those who have the competence of a managerial physician, referred to in the text, will have an obvious advantage in comprehending the special inter-disciplinary characteristics of New Public Health. Informed criticism from them will be vital for the growth and development of new ideas. Unfortunately, such managerial physicians are becoming a rapidly vanishing species. They need to be protected and nurtured so that it is possible to bring them together to form the critical mass of competence referred to in the preceding chapter.

It is fondly hoped that this book will also serve as a catalyst for the formation of a new generation of scholars in public health who have a wide range of interdisciplinary competence. For them, seeped as they are in conventional wisdom of public health within the country and abroad, it would be a hard, grinding task of comprehension. They will have to actively resist the temptation of covering up their own inadequacies in comprehension by coming out with uninformed, ill-informed or superficial criticism of the ideas presented here. That will be most unwelcome!

The author is venturing to anticipate the possible responses because of his experience with the responses to what he considerd his *magunum opus – Health and Family Planning Services in India: An Epidemiological, Socio-cultural, and Political Analysis and a Perspective (1985).* A large number of copies of this book have been sold. There have been scholars who have written to the author how they had carefully gone through the book from cover to cover on more

than one occasion. There have been some valuable comments and criticism. However, they were not many in number.

The author is mildly and pleasantly surprised with himself when he finds that through the present book he has been able to impart greater depth and width to what he had been able to say in his 1985 book. It, in fact, is a supplement to that book. With this, it is fervently hoped, that there would be much more extensive debate amongst informed scholars about the ways of dealing with the present sickness of the health service system, We have had enough of quacker (clike the Area Projects) and black magic (like the UIP)!

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ANNEXURE - A

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ANNEXURE B

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